Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Wyoming** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Acquired Brain Injury Waiver

C. Waiver Number: WY.0370
Original Base Waiver Number: WY.0370.

D. Amendment Number: WY.0370.R02.01

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/10

Approved Effective Date: 07/01/10
Approved Effective Date of Waiver being Amended: 07/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of the amendment is to:

* Add self-direction to the waiver,
* Add new services to the waiver to support self-direction and
* Add more flexibility to service options for waiver participants
* Modify some service definitions to better reflect the services allowed under a service definition
* Adjust rates to reflect a legislative appropriation for provider service rates
* Add the ICAP contractor and Financial Management Service Contract and monitoring to Appendix A
* Clarify general description and edit/update performance measures in Appendix A
* Update the Level of Care process to what the DD Division currently has in place.
* Update sections in Appendix D to reflect current processes in place for service plan development and monitoring
* Update sections in Appendix G to reflect current changes to processes in place for participant safeguards.
* Update processes in Appendix H
* Update Appendix I to add rate methodology for self-directed service rates and ranges
* Clarify general description and edit/update performance measures in Appendix I
* Update Appendix J to show rates and estimates for new services

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☑ **Appendix A – Waiver Administration and Operation**	all but 1
☑ **Appendix B – Participant Access and Eligibility**	6 d and f
☑ **Appendix C – Participant Services**	1, 3, 4
☑ **Appendix D – Participant Centered Service Planning and Delivery**	1-b,c,d 2-a,
☑ **Appendix E – Participant Direction of Services**	all
☐ **Appendix F – Participant Rights**	
☑ **Appendix G – Participant Safeguards**	1, 2
☑ **Appendix H**	1-a-i
☑ **Appendix I – Financial Accountability**	1, 2-a
☑ **Appendix J – Cost-Neutrality Demonstration**	2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☑ **Add/delete services**
- ☑ **Revise service specifications**
- ☑ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☑ **Add participant-direction of services**
- ☑ **Other**

  Specify:
  Modify the prospective individual budget amount narrative in Appendix C-4, clarify language in Appendicies A&I, and update QIS for Appendices A&I.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Wyoming** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Acquired Brain Injury Waiver

C. Type of Request: amendment

Original Base Waiver Number: WY.0370
Waiver Number: WY.0370.R02.01
Draft ID: WY.06.02.01

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/09
Approved Effective Date of Waiver being Amended: 07/01/09

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The Acquired Brain Injury (ABI) Waiver is administered through the Wyoming Department of Health, Developmental Disabilities (DD) Division within the Single State Medicaid Agency (referred to as the DD Division in this application). The ABI Waiver's mission is to assist participants and their families in obtaining the retraining, services and supports needed to keep participants in their home communities. This program is available across the entire state and individuals ages 21 to 65 can access services. Clinical eligibility for the waiver is determined by the Division's review of medical records, neuropsychological evaluation, Inventory of Client and Agency Planning (ICAP) assessment, and the Level of Care determination.

Once clinical eligibility is determined and there is a funding opportunity, the Division generates the individualized budgeted amount (IBA) and notifies the participant and/or guardian of the funding opportunity and of their budgeted amount. Financial eligibility is then verified through the Department of Family Services. Using a person-centered approach, the participant and the team work together to develop a plan of care that will allocate that Individually Budgeted Amount for needed waiver services. The plan of care also identifies non-waiver services needed by the participant. Once the participant and the team complete the plan of care, the participant's case manager submits the plan to the DD Division for review and approval.

Plans are approved for no longer than one year. However, a guardian, participant, case manager or any other team member can request a revision to the plan of care at any time during the plan year. When this occurs, the participant works with the case manager and the team to determine what modifications are needed. The modification is prepared by the case manager, signed by the participant and/or guardian, and sent to the DD Division for review and approval.

The DD Division reviews and approves all plans of care and modifications to plans of care. The DD Division's plan of care and plan modification approval process focuses on assuring the plan addresses the participant's personal goals and assessed needs, including health and safety risk factors, and to assure there is no duplication of payment for waiver services listed in the plan, or services that may be covered under the Medicaid state plan or by other sources. The DD Division signs and dates the preapproval page of the plan of care and returns the signed preapproval page back to the case manager verifying approval of the plan. Services can begin the day the plan or modification to the plan is approved by the DD Division. The case manager distributes the signed pre-approval form to the participant or guardian and all providers on the plan, thereby notifying them that services can begin.

The DD Division sends the information on approved services electronically to the Medicaid Management Information System (MMIS) that generates a prior authorization number. The provider receives written notification of the prior authorization number from the MMIS.

All providers certified to provide ABI Waiver services are required to have a current provider agreement in place with the State Medicaid Agency. Participants and guardians can choose a case manager employed by a provider agency or a self-employed case manager. Participants and guardians also have choice of over 500 ABI service providers in Wyoming.

CMS is requiring the state to utilize the National Quality Enterprise (NQE) for technical assistance regarding the Quality Improvement Strategy (QIS) for global performance measures and related implementation activities that affect the ABI Waiver (WY 0370.R02.00). The state along with assistance from the NQE will develop goals for the quality improvement

strategy and a related work plan with associated steps that address design, development, and implementation of specific performance measures and related remediation and improvement strategies. The work plan is subject to CMS approval. In order to realize the work plan for revamping the QIS, the appropriate utilization of performance measures and implementation of remediation the State will hold monthly meetings, starting August 1, 2009 in which it will update CMS and Thomson Reuters on its accomplishments relative to work plan (these monthly monitoring meetings should also be accompanies by written documentation, a format where the State can update the plan with notes on its accomplishments). Once the work plan is achieved, these meetings can stop after formal CMS acknowledgement. The State recognizes that further development of performance measures is needed and intends to utilize the 372 reporting process to incorporate other performance measures and updates to the QIS during this process.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

○ **Not Applicable**
◉ **No**
○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

◉ **No**

○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care

specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or

(b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The DD Division began working on adding self-direction to the waiver programs in 2006. Public forums were held throughout the state in early 2007 to provide information on self-direction and to gather input on the services, supports and structures people most wanted to see in self-directed waiver services. At the end of 2008, an internal working group of Division staff reviewed information and input obtained from the forums held in 2007 to begin developing the framework for self-directed services and possibly a new supports waiver.

The DD Division has presented the framework for the self-directed services and a supports waiver to the DD Division's Advisory Council and updated the Council on the progress made on the framework during the past three quarterly meetings. The Council was given the opportunity to provide input on the framework during each of these meetings. The DD Advisory Council includes representation from Protection & Advocacy Systems Inc., the Governor's Council for Developmental Disabilities, Wyoming Department of Education, Wyoming Institute for Disabilities, waiver service providers, and recipients of waiver services.

The DD Division informed participants and providers of the proposed framework for the self-directed services and a supports waiver through letters and a listserv email sent to all participants and providers in August 2009. The letters and email gave information on two plans, submitting a new "supports" waiver and amending the ABI DD waiver to add self-direction and some new services. Instructions were given on how the public could receive further information on the development of the supports waiver and keep informed on any decisions made by the Division on the other current waivers. A schedule of public forums being held across the state was distributed to explain the proposals for the waiver and to obtain input. Fifteen public forums were held throughout the state in August and September 2009. 498 people attended the forums, including:* 38 participants* 117 Parents/guardians* 11 family members* 279 providers* 39 parents/guardians who are also providers* 14 representatives from other agencies.

The public was also informed in the letter that further information on the changes to the waivers could be viewed on

the DD Division's website, where there is also a link for people to provide written input on the framework for the "supports" waiver and self-directed services. The website includes a list of Frequently Asked Questions (FAQ), which is updated as new questions are submitted. People attending the forums were able to submit written questions for inclusion in the FAQ document. Over 200 questions have been submitted, and the DD Division responded to questions as they were received.

The DD Division also organized work groups to assist the DD Division in the final development of the waiver service changes and self-direction components. There was one work group for each of the following areas: Case Management and Support Broker; the new waiver services. Participation in the work group was voluntary and included participants, families, guardians and providers, in total 49 people participated in the groups and numerous others received information and provided input but were not members of the various groups. A summary of the results of the work groups was posted on the waiver project website.

In addition, statewide public meetings were held November 9 to 13, 2009 in Cheyenne, Casper, Sheridan, Gillette, Torrington, Newcastle and Laramie to introduce the financial management service; Public Partnerships Limited (PPL), and to respond to questions regarding how participants will interact with PPL. There were 10 meetings held and they were attended by 109 of people. Eight additional public meetings are being held November 30 through December 3, 2009 in the following places: Jackson, Pinedale, Afton, Evanston, Rock Springs, Riverton, Worland and Cody. The PPL Participant Handbook has also been posted on the project website.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Swistowicz
First Name:	Beverly
Title:	Aquired Brain Injury and Children's DD Waiver Manager
Agency:	Developmental Disabilities Division
Address:	6101 Yellowstone Road, Suite 186E
Address 2:	
City:	Cheyenne
State:	**Wyoming**
Zip:	82002
Phone:	(307) 777-3321 **Ext:** ☐ **TTY**
Fax:	(307) 777-6047
E-mail:	beverly.swistowicz@ health.wyo.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	

First Name:	
Title:	
Agency:	
Address:	
Address 2:	
City:	
State:	**Wyoming**
Zip:	
Phone:	**Ext:** ☐ **TTY**
Fax:	
E-mail:	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Teri Green
	State Medicaid Director or Designee
Submission Date:	Jun 2, 2010

Last Name:	Green
First Name:	Teri
Title:	State Medicaid Agent
Agency:	Wyoming Department of Health, Office of Healthcare Financing
Address:	6101 Yellowstone Road, Suite 210
Address 2:	
City:	Cheyenne
State:	**Wyoming**
Zip:	82002
Phone:	(307) 777-7908
Fax:	(307) 777-6964
E-mail:	teri.green@health.wyo.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The renewal of the ABI Waiver includes the changes described below. The DD Division obtained input on the changes as described in the main section of this application, under 6-I.

Participants and guardians, as well as case managers impacted by these changes, were notified by letter by June 1, 2009. The letter explained the process to change to another service, which includes working with the case manager and the participant's plan of care team to discuss other service options that are available within the individual budgeted amount. After the participant and guardian determine the appropriate changes in services, the case manager must submit a modification to the plan to the DD Division for review and approval. These changes will not result in a participant losing waiver eligibility and the participant's plan of care team will be able to modify the existing plan of care to add the appropriate service(s) so that one's health and safety are not affected. The letter included the process to request a Fair Hearing.

Changes:
1. Prevocational Service is being eliminated so that services can more accurately reflect the supports individuals are receiving, either through Day Habilitation or Supported Employment.

Transition Plan for ABI Waiver Participants Currently Receiving Prevocational Services:
Nineteen ABI Waiver participants will need to change from Prevocational Services to either Day Habilitation or Supported Employment. This change will not be required until October 1, 2009 to give the participant and team time to review the services options and revise the plan of care. The deadline for submitting modifications to the plan of care is September 1, 2009 so the DD Division has sufficient time to review and approve each modification in services.

2. In-Home Support Service is being removed so that services can more accurately reflect services received either through Supported Living or Personal Care.

Transition plan for ABI Waiver Participants Currently Receiving In-Home Support Services:
Fifty-one ABI Waiver participants will need to change from In Home Support Services and choose either Supported Living Services or Personal Care Services, depending on the service that best meets their needs. This change will not be required until October 1, 2009 to give the participant and team time to review the services options and revise the plan of care. The deadline for submitting modifications to the plan of care is September 1, 2009 so the DD Division has sufficient time to review and approve each modification in services.

3. Supported Living Service is being added to more accurately reflect the supports participants are receiving who currently live in their own home, family home, or rental unit and who do not require ongoing 24-hour supervision but do require a range of community-based support to maintain their independence.

Transition plan for ABI Waiver Participants Moving to Supported Living Services from intermittent Residential Habilitation Services:
Up to twenty-five ABI Waiver participants currently receiving residential habilitation service will need to meet with their teams to evaluate their living arrangements and provide documentation for the most appropriate service; either Residential Habilitation with 24 hour ongoing staff supervision or Supported Living with staff available. When necessary, a modification to the plan of care will be submitted to the DD Division. This documentation will be submitted to the DD Division no later than November 30, 2009 to give the participant and team time to evaluate the living arrangements and to submit the required documentation.

4. The definition for Personal Care has been expanded to include instrumental activities of daily living (IADLs) and will have a restriction on the number of units allowed on a plan. (Based upon need and limited to 7,280). The broadening of the service definition to include IADL's makes this service available to more ABI Waiver participants who are living semi-independently but need assistance in those areas. The cap has been added to assure participants are receiving this service appropriately. Participants requiring more than 7,280 units of Personal Care may require a higher level of service such as Supported Living or Residential Habilitation. If a participant needs units above the cap limit and the use of other waiver services are not sufficient or appropriate to meet a person's needs, the request shall go through the DD Division's Extraordinary Care Committee for approval.

Transition Plan for ABI Waiver Participants Currently Receiving Personal Care Services over Newly Implemented Cap:
Those ABI Waiver participants who currently are exceeding the maximum limit for Personal Care units under the newly implemented cap will be required to make the required plan adjustments no later than their plan renewal date. The plans may be modified earlier than that date.

5. Respite Service has been better defined to reflect the Centers for Medicare and Medicaid Services (CMS) guidance that respite services are intended on a short-term basis when the caregiver is absent or needs relief and are episodic in nature. Respite will have a restriction on the number of units allowed on a plan. (Based upon need and limited to 7280).

Transition Plan for ABI Waiver Participants Currently Receiving Respite Services Over the Newly Implemented Cap:
Those ABI Waiver participants who currently are exceeding the maximum limit for respite units under the newly implemented cap will be required to make the required plan adjustments no later than their plan renewal date. The plans may be modified earlier than that date. If a participant needs units above the cap limit and the use of other waiver services are not sufficient or appropriate to meet a person's needs, the request shall go through the DD Division's Extraordinary Care Committee for approval.

6. Day Habilitation for the daily unit will require a minimum of 4 hours in service. A 15-minute unit will be added for those ABI Waiver participants who routinely have less than 4 hours of service a day.

Transition Plan for Participants Currently Receiving less than 4 hours of Day Habilitation Services:
Those ABI Waiver participants who are not currently receiving at least 4 hours of Day Habilitation daily must meet with their teams and modify the plan of care to accurately reflect the services being delivered. This change will not be required until October 1, 2009 to give the participant and team time to review the services options and revise the plan of care. The deadline for submitting modifications to the plan of care will be September 1, 2009 so the DD Division has sufficient time to review and approve each modification in services.

7. Residential Habilitation will have targeting criteria for new people who come on to the waiver and for ABI Waiver participants not currently receiving Residential Habilitation Services. Waiver participants, who are not receiving 24-hour residential services but are at significant risk due to extraordinary needs that cannot be met in current living arrangement, may request Residential Habilitation Services if the participant meets targeting criteria detailed under the Residential Habilitation Service definition in Appendix C.

Transition Plan for Targeting Criteria for Residential Habilitation Services:
No ABI Waiver participants currently receiving Residential Habilitation Services will need to change services so no transition plan is required. However, effective July 1, 2009, any proposed move to a residential placement must meet the criteria listed in Appendix C.

8. Case Management changes: In order to address safeguards that must be in place when the state allows case managers to provide other services on a plan of care, the following changes will be put in place by December 31, 2009. More information on these changes is found in Appendix C-1-B and D-1-B of this application.
• Case managers currently employed by organizations that are certified to provide case management services will be required to be certified as a case manager under their own provider number
• Effective July 1, 2009 the plan of care includes a conflict of interest statement that summarizes how conflict will be addressed, how the best interest of the participant is assured, how monitoring will be enhanced, and what actions the participant/guardian should take if he or she has concerns with any aspects of the case manager’s roles and responsibilities.
• Case managers will be required to have policies and procedures in place addressing conflicts of interest when a case manager is providing other services on the plan of care
• The Division will develop a web-based complaint system so participants, guardians, and others can easily file a complaint with the Division, including complaints regarding the conflict of interest if a case manager is not working in the best interest of the participant.

Transition Plan for Case Management Safeguard Changes:
The DD Division will work with each case manager employed by an organization to assist them in obtaining their own provider number and in developing appropriate policies and procedures that are compliant with state standards. As needed plans of care will be revised to reflect the actual case manager for the participant, not the organization's name. These changes will be in place by December 31, 2009. ABI Waiver Participants and guardians will continue to be able to choose their case manager, but will have expanded options since they will be able to choose a specific case manager within an organization or a self employed case manager.

9. A new state policy for Medication Assistance goes into effect July 1, 2009 that includes new requirements for an Approved Medication Assistant, which will be a qualified person trained to assist with medications according to the new DD Division's standards. More information on these changes is found in Appendix G-3.

Transition Plan for Medication Assistance Requirements:
The state policy includes new requirements for an Approved Medication Assistant, which is the qualified person trained to assist with medications according to the new DD Division's standards. The DD Division will have the core training

curriculum for Medication Assistance developed by July 1, 2009. Provider training for the curriculum will begin in July with a statewide training for all providers who can attend, using a train-the-trainer approach. The providers will then be able to return to their agencies and begin training the staff they choose on the curriculum and establishing core staff to be Approved Medication Assistants. The training will be held once a month by the DD Division after July for three months, then quarterly thereafter. The state's training can certify people to be an Approved Medication Assistant, or with additional training, certify a person to be an Approved Medication Assistant trainer. Providers who assist participants with medications, will have until December 31, 2009 to certify enough staff necessary to comply with the state's policy, so each participant has an Approved Medication Assistant or other qualified person assisting with medications according to their medication regimens.

Changes have been made to the plan of care effective July 1, 2009 to include more required information from the team on conflict of interest, risk management, back up plans and employment planning.

The DD Division will track the implementation of these changes weekly to assure time lines are being met. If barriers arise that may result in delay in implementation of a change, the DD Division will work with the State Medicaid Agent and other appropriate entities to address the barrier quickly so the delay does not result in missing the implementation deadline.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

If the participant chooses to receive services through traditional providers, the participant and his/her circle of support folllow the same basic planning process as described in Appendix D. Once the appropriate services are identified, the case manager reviews the list of service providers in the geographic area and assists the participant as needed in interviewing and choosing providers. The case manager completes the plan of care and submits it to the DD Division for approval before services are authorized. Modifications can be made to the plan as needed during the year and will be reviewed and approved by the DD Division.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ◉ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   Developmental Disabilities Division
   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
(a) The functions performed by the Developmental Disabilities Division

The Developmental Disabilities Division performs the following functions:
(1) Develop and implement standards for the operation of the waiver;
(2) Develop administrative rules, written policies and procedures for the waiver;
(3) Verify qualifications for waiver providers;
(4) Track and manage utilization, expenditures, participant counts, costs, and waiting list information;
(5) Track waiver performance measure data and trends related to the data;
(6) Set and implement provider rates;
(7) Participate in activities designed to identify and prevent fraud and abuse of Medicaid resources;
(8) Develop and implement written standards for quality assurance measures, especially those related to level of care, service plans, provider qualifications, and health and welfare of participants;
(9) Monitor providers to ensure compliance with policies, procedures, quality assurance standards, service definitions, billing procedures, federal rules, regulations and guidelines;
(10)Provide Program Integrity Manager reports of monitoring activities of providers;
(11)Provide Program Integrity Manager information sufficient to monitor waiver expenditures, service appropriateness, and accuracy of billing by providers;
(12)Meet with State Medicaid Agent or Programs Coordinator at least monthly to review issues related to the operation of the waiver;
(13)Monitor and report to the Medicaid Agent or Programs Coordinator information related to expenditures and capacity for the waiver.

(b) The document utilized to outline the roles and responsibilities related to waiver operation

The Department of Health has a Letter of Agreement between the Office of Healthcare Financing and the Developmental Disabilities Division which outlines the roles and responsibilities related to waiver administration and operation and documents the administrative authority of the State Medicaid Agent for the operation of the Acquired Brain Injury Home and Community Based Services Waiver.

(c) Methods that are employed by the State Medicaid Director in the oversight of these activities
The Wyoming Department of Health is the Medicaid Agency and the ABI Waiver is operated by the Developmental Disabilities Division within the Department of Health, under the direction of the State Medicaid Agent. The State Medicaid Agent reports to the Director of the State Medicaid Agency through the Deputy Director of Administration.

The Administrator of the Developmental Disabilities Division reports to the Director of the State Medicaid Agency through the Deputy Director of Administration. There is a Letter of Agreement between the Office of Healthcare Financing and the Developmental Disabilities Division outlining the responsibilities of each entity.

A new Programs Coordinator position was created within the Medicaid Office to maximize oversight of and involvement in the day to day operations of the HCBS waivers. This position was filled on September 1, 2008 and reports directly to the State Medicaid Agent. Under the direction of the State Medicaid Agent, the Programs Coordinator has oversight over the administrative and operational functions of the waiver performed by the Developmental Disabilities Division. The Programs Coordinator works closely with the Program

Integrity Manager within Medicaid to identify areas that need increased involvement and oversight by the State Medicaid Agent. The State Medicaid Agent, Programs Coordinator, Program Integrity Manager, Senior Eligibility Manager, and Operations Manager, who combined provide oversight over all areas of the Medicaid waivers, report directly to the State Medicaid Agent within the Office of Healthcare Financing.

The State Medicaid Agent or her designee reviews and approves all rules, contracts, written policies and procedures, and rates developed or changed by the Developmental Disabilities Division related to the operation of the ABI waiver prior to implementation.

The Programs Coordinator has weekly contact with the Policy and Research Analyst within the Developmental Disabilities Division. A monthly meeting is held by the Programs Coordinator for representatives of all HCBS waivers. The Policy and Research Analayst is the waiver representative from the Developmental Disabilities Division. The goal of these meetings is to keep the Programs Coordinator abreast of the day to day management activities of the waivers, to create as much consistency across the waivers as possible, and to provide adequate oversight of the waiver programs to ensure compliance with federal and state regulations and requirements. The direct supervisors of the Waiver representatives often attend these meetings and are kept current on requirements and concerns through additional status meetings and e-mails. After reviewing quarterly performance measure reports for the waiver, these Waiver meetings will be one vehicle for providing feedback to the Waiver representatives from the State Medicaid Agent or her designee. Additionally, the Programs Coordinator will hold meetings quarterly with DD Waiver staff to discuss information from management reports on topics such as utilization, expenditures, participant counts, waiting lists, and performance measure data trends.

The Medicaid Agent is represented by one or more designated staff at Developmental Disabilities Division meetings concerning HCBS waivers such as ECC and Mortality Review. Agenda items are documented, discussed, and tracked until resolution.

Medicaid Waiver staff from the Developmental Disabilities Division attends monthly Medicaid staff meetings, monthly CURT (Core Utilization Review Team) meetings, and monthly MMIS status meetings.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
Medicaid has a contract for the operation and management of the MMIS system to review and pay all claims submitted by providers for the Acquired Brain Injury Waiver. This Contractor assists the State with Prior authorization, provider enrollment, and the execution of provider agreements. For prior authorization, the Contractor generates the prior authorization number after the Division loads the approved service plan into the client database which interfaces with the MMIS system. For provider enrollment, the Contractor processes the Medicaid provider enrollment application after the Division certifies the provider. For provider agreements, the Contractor executes and stores the provider agreements according to contractor requirements.

Medicaid has a utilization review contract which includes case review for the Developmental Disabilities Division's Mortality Review Committee. Cases reviewed by the committee includes Acquired Brain Injury participants.

The Developmental Disabilities Division has a contractor to conduct Inventory for Client and Agency Planning (ICAPs) for ABI DD Waiver applicants and participants as part of the clinical eligibility process for the waiver.

The Developmental Disabilities Division has a contractor to provide Financial Management Services for participants or their representatives self-directing services on the ABI Waiver. The contractor completes all responsibilities related to self-direction as described in Appendix E of this application, bills MMIS for services provided by participants' workers, tracks utilization of services by participant, provides utilization information on a monthly basis to participant, case manager, support broker and DD Division, processes time sheets and pays workers.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Office of Healthcare Financing, within the State Medicaid Agency (Department of Health), has a MMIS Contract Manager who assesses the on-going performance of the MMIS contractor. Additionally, the Program Integrity Manager and the Waiver Manager Review information provided under this contract related to prior authorization, provider enrollment, and provider agreements.

The Utilization Contract Manager for Medicaid assesses the performance of the Utilization Review contractor related to Mortality Review for the Acquired Brain Injury waiver. The Contract Manager works closely with the Provider

Support Manager in the Developmental Disabilities Division, who is Chair of the Mortality Review Committee.

The Participant Support Manager of the Developmental Disabilities Division monitors the timeliness of the ICAPs conducted to ensure compliance with the contract.

The Provider Support Manager in the Developmental Disabilities Division oversses the monitoring process for the Financial Management Service provider, which includes a review of records to assure adherence to IRS and federal, state and local rules and regulations, timely and accurate processing of time sheets, timely and accurate maintaining of current participant budget information, and assessment of participant/representative and worker satisfaction with FMS services. Processes are explained in Appendix E of this application.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Contract Manager for the MMIS contract assesses the performance and compliance of the contractor on an on-going basis based on requirements in the RFP and contract, and the Business Rules provided to the contractor by Medicaid. Monthly contract management meetings are held by the Contract Manager with the contractor to review the status of projects and to address any identified problems. Regular status meetings are held by the contractor to update the Contract Manager, the Program Integrity Manager, and the Waiver Manager, to review project lists and monitor timeline for completion. Minutes of each meeting are kept and distributed to each person who attends the meeting. The MMIS Contract Manager communicates identified contract issue to the Waiver Representatives, Program Integrity Manager, and Programs Coordinator as necessary.

The Contract Manager for the Utilization Review contract assesses the performance and compliance of the contractor on an on-going basis based on requirements in the RFP and contract. Weekly contract meetings are held by the Contract Manager with the Contractor to review the status of projects and to address any identified problems. The Contract Manager attends the quarterly Mortality Review Committee meetings held by the Developmental Disabilities Division and monitors the case review information provided by the Contractor for the meetings. Monitoring criteria includes making sure the Contractor requested and obtained records based on six month claim period, did an objective and thorough case review, and submitted a timely written report of the findings to the Survey/Certification Manager at the Developmental Disabilities Division for use at the meetings.

The Participant Support Manager of the Developmental Disabilities Division monitors the timeliness of the ICAPs conducted monthly to ensure compliance with the contract. The contractor records the time it took to complete each ICAP on a spreadsheet which is submitted to the DD Division monthly for review. The DD Division also monitors any concerns with the ICAPs conducted and meets with the contractor as needed to follow up on concerns. The Medicaid Agent or her designee in the Office of Healthcare Financing reviews the quarterly Management Report provided by the DD Division which details contract oversight activities and findings.

The state has developed a tiered approach to monitoring the performance of the Vendor Fiscal Employer Agent Financial Management Service, including oversight by the case manager, DD Division, and Medicaid's Program Integrity Unit.

1. The case manager reviews the performance of the Vendor Fiscal Employer Agent Financial Management service during the required monthly home visit with the participant. The case manager is required to document the specific concerns, complete and document follow-up actions to address the concerns, and assure the concerns are resolved. Follow-up includes, as appropriate:

• Direct contact with the Fiscal Employer Agent Financial Management Service informing them of concerns and working with them to resolve the issues.
• Meeting with appropriate parties involved, including the Support Broker, employee of participant who is involved in

situation, and Vendor Fiscal Employer Agent Financial Management Service representative, to work through the concerns.
• Reporting issues to the DD Division if significant concerns are identified that impact health and safety, indicate potentially fraudulent activity, and/or if concerns are not addressed by Vendor Fiscal Employer Agent Financial Management after the case manager has worked directly with them. A summary of issues reported to the Division by

the case manager and action taken by the Division will be forwarded to the State Medicaid Agent or her designee.

2. The DD Division monitors the Vendor Fiscal Employer Agent Financial Management Service through the following
processes:

• Monitoring the Vendor Fiscal Employer Agent Financial Management monthly budget utilization reports for all participants self-directing services to assure reports are accurately reflecting service utilization, reviewing flagged participants who are over utilizing or under utilizing their budgets, and business rules are adhered to, including rules on service limitations.
• Completing an biennual review of Vendor Fiscal Employer Agent Financial Management Services for a representative sample of individuals utilizing this service. The representative sample will have a confidence interval of 95% +/- 5% error rate. The review will include: (a) a review of individuals' files to verify the Vendor Fiscal Employer Agent Financial Management Service has all
employee information on an individual and verification of withholdings as detailed in Appendix E (b)customer satisfaction interviews with both the common law employer (participant or their legal representative) and employees to assess the satisfaction of Fiscal Employer Agent Financial Management Service, including timely processing of timesheets, timely resolution to customer service calls and complaints, and assistance in completing enrollment packets and (c)a review of the Vendor Fiscal Employer Agent's contract.

3. Based on the representative sample pulled by the DD Division, The Medicaid Program Integrity Unit will review claims paid to providers through the following processes:
* Reviewing claims paid to the Vendor Fiscal Employer Agent Financial Management Service and supporting documentation to verify that the documentation supports the billing and payment for services.
* Recovering funds paid to the Vendor Fiscal Employer Agent for claims for which services are not sufficiently documented.

The DD Division will complete an annual review of the Vendor Fiscal Employer Agent business practices to verify all required IRS regulations, as well as state unemployment and worker's compensation regulations. The DD Division will request a copy of independent audits conducted by the vendor. If concerns are found through any of these processes the Vendor Fiscal Employer Agent Financial Management Service will be required to address the concerns within a specified time period, and, when applicable, to pay corresponding penalties and fees. The vendor's contract includes clauses for termination of contract if serious concerns are identified. A summary of annual review findings by the Division will be forwarded to the State Medicaid Agent or her designee.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑

Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☑
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of Inventory for Client and Agency Planning (ICAP) assessments for ABI participants completed within 30 calendar days from the date the ICAP was requested. (the total number of ICAP assessments completed within 30 calendar days of request divided by the total number of ICAPs requested)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ICAP spreadsheet report with dates of requests and completions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: ICAP database maintained by contractor completing ICAPS	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of waiver prior authorization error reports which are reviewed by Medicaid to assess Contractor performance. (the total number of waiver prior authorization error reports reviewed by Medicaid divided by the number of waiver prior authorization error reports created)

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of rules, contracts, rates, and policies/procedures related to the ABI waiver submitted by the DDD that have been approved by the State Medicaid Agent or designee prior to implementation. number of rules, contracts, rates, and policies/procedures approved by SMA prior to implementation divided by the total number of rules, contracts, rates and policies/procedures implemented by the DDD.

Data Source (Select one):
Other
If 'Other' is selected, specify:

database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of quarterly reports provided by the DD Division for which a feedback

meeting is held by the State Medicaid Agent or her designee to provide recommendations and direction. (the total number of feedback meetings held by the State Medicaid Agent or designee divided by the number of quarterly reports submitted by the DD Division for review)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
Percentage of Contractor reports provided to the Mortality Review Committee that were complete. (total number of Mortality Review Committee reports that were complete divided by the number of Mortality Review reports that were submitted by Contractor)

Data Source (Select one):
Other
If 'Other' is selected, specify:
database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of call center reports reviewed by DD DIvision to assess contractor performance. (total number of call center reports reviewed by DD Division divided by the number of call center reports submitted by Contractor to the DD Division)

Data Source (Select one):
Other
If 'Other' is selected, specify:
database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Methods for remediation with contractors include: verbal and written notification to the contractor about any concerns the State has with performance as soon as they are identified, education and guidance provided to the Contractor stating the State's expectations for performance under the contract, and modifying the langauge in the contract to more clearly articulate the expectations of the State. If contractor performance does not improve, the contract can be terminated.

Methods for remediation with the Division include feedback given by the Programs Coordinator to the Policy and Research Analyst in the DD Division and if necessary, feedback given by the State Medicaid Agent to the Administrator of the Devleopmental Disabilities Division about expectations related to the operation of the waiver. If that communication is not successful in resolving the concern, concerns can be discussed at monthly Department of Health Senior Management meetings, directed by the head of the State Medicaid Agency.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ○ **No**
- ◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The State recognizes that the MMIS contract applies to the Medicaid Program in general and does not specifiy performance specific to the waiver program. The State will add an additional performance measure for contractor performance related to provider enrollment for the waiver program by Septemeber 30, 2010.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
◉ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☑	**Brain Injury**	21	64	☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
○ **Mental Retardation or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Mental Retardation**			☐
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Additional targeting criteria for eligibility on the ABI Waiver includes:

Medical Eligibility - Determined by a licensed physician and registered nurse who reviews the medical documentation submitted by the applicant and verifies that this documentation meets the definition of acquired brain injury as listed below:

Acquired Brain Injury - any combination of focal and diffuse central nervous system dysfunction. Both immediate and/or delayed, at the brain stem level and above. These dysfunctions are acquired through the interaction of any external forces and the body, oxygen deprivation, infection, toxicity, surgery and vascular disorders not associated with aging. It is an injury to the brain that has occurred since birth. It may have been caused by an external physical force or by a metabolic disorder(s). The term acquired brain injury includes traumatic brain injuries such as open or closed head injuries and non traumatic brain injuries such as those caused by strokes, tumors, infectious diseases (e.g. encephalitis or meningitis), hypoxic injuries (e.g. asphyxiation, near drowning, anesthetic incidents, or severe blood loss), metabolic disorders (e.g., insulin shock or liver or kidney disease), and toxic products taken into the body through inhalation or ingestion. The term does not include brain injuries that are congenital or brain injuries induced by birth trauma. These dysfunctions are not developmental or degenerative.

Clinical Eligibility
A neuropsychological examination will be administered by a licensed psychologist who has at least one year of post doctoral work in acquired brain injury. The neuropsychological examination will confirm that the individual meets the ABI definition and meets any of the following functional criteria:

Mayo Portland Adaptability Inventory (MPAI) score of 42 or more
California Verbal Learning Test II Trials 1-5 T score of 40 or less
Supervision Rating Scale score of 4 or more
Inventory for Client and Agency Planning(ICAP) service score of 70 or less (ICAP administered by a contracted agency)

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Individuals who are already receiving services on the ABI waiver and turns 65 years old may remain receiving waiver services. No one 65 or older may apply for waiver services.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

● **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Once there is a funding opportunity, the DD Division generates the individualized budget amount and notifies the participant and/or guardian of the funding opportunity and of their budgeted amount. Using a person-centered approach, the participant, the case manager and the team work together to develop a plan of care that will allocate that individualized budget amount for needed waiver services. The plan of care also identifies non-waiver services needed by the participant. If the participant and/or guardian with support from the plan of care team identifies that the plan of care developed within the budgeted amount will not meet the participant's health and welfare needs the participant can request additional funding through the DD Division's Extraordinary Care Committee, described below.

The additional funding being requested cannot exceed the institutional cost limit for the waiver. If it does, the participant is denied entrance into the waiver, and is offered an opportunity to request a Fair Hearing by letter. The participant is also provided information on other service options, including the Adult Developmental Disabilities Waiver if the injury occurred before the age of 21; the Long Term Care Waiver; an acquired brain injury program housed on the campus of the ICF/MR institution; or a nursing home.

If the additional funding being requested does not exceed the institutional cost limit, the request is evaluated by the DD Division's Extraordinary Care Committee, which has the authority to evaluate and approve requests for additional funding above a participant's individualized budget amount due to a material change in circumstance, a potential emergency or other condition justifying an increase in funding. The Extraordinary Care Committee's membership includes the Waiver Manager, the DD Division's Fiscal Manager, and a representative from the State Medicaid Agency. The committee reviews information compiled by the participant's case manager that details the reasons for the need for increased funding, including specific health and welfare needs that are not able to be adequately addressed within the individualized budgeted amount.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- [x] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [x] **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

The DD Division, through the Extraordinary Care Committee process, may authorize a temporary increase in an ABI Waiver participant's individualized budgeted amount that results in the individualized budgeted amount being above the institutional cost limit for the waiver. The additional funding may be approved for up to one year to address emergent health and welfare needs.

If due to a significant change in health or welfare needs a participant requires a permanent increase in funding that is above the institutional cost limit for the waiver, the DD Division notifies the participant, guardian and case manager in writing that the participant is no longer eligible for the waiver effective 90 days from the date of notification. The Division's notification includes a referral to the Adult Developmental Disabilities Waiver if the injury occurred before the age of 21 and includes information on other services that may be available to the participant. The participant is also offered an opportunity to request a Fair Hearing.

- [ ] **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	215
Year 2	215
Year 3	215
Year 4 (renewal only)	215
Year 5 (renewal only)	215

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	200
Year 2	200
Year 3	200
Year 4 (renewal only)	200
Year 5 (renewal only)	200

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

When there is sufficient funding, individuals are admitted to the waiver upon completion of the clinical and financial eligibility process.

Per Wyoming Medicaid rules, Chapter 43, Section 13, when there is insufficient funding to add additional participants, the DD Division maintains one waiting list for the ABI Waiver as specified below.

The DD Division assigns two rankings to each person on the waiting list based on the following two factors:

1) The severity of the person's condition based on the Mayo Portland Adaptability Inventory, the California Verbal Learning Test II Trials 1-5 T score, the Supervision Rating Scale, and the Inventory for Client and Agency Planning (ICAP)
2) The person's placement date on the waiting list.

When covered services become available, the DD Division alternates between the two factors beginning with the waiting list based on severity, in selecting the next person to whom covered services shall be provided.

In cases when the severity levels are the same or when the placement date on the waiting list is the same, the DD Division uses the date that the Case Management Selection form was received by the DD Division to determine which name goes first on the waiting list.

The DD Division determines the availability of funding for the approved individualized budget amounts for applicants on the waiting lists waiting for funding opportunities.

The DD Division can also fund a person from the ABI Waiver waiting list if it is determined he or she is in an emergency situation, such as homelessness or loss of primary caregiver. The DD Division, through the Extraordinary Care Committee (ECC) has established criteria to determine if a situation is an emergency,and reviews pertinent information to determine if the situation meets the emergency criteria.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (•) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and*

community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- (•) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- (•) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount:

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

Specify percentage amount:

- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- (●) **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - ( ) **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - (●) **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

- ( ) **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ( ) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The special income level for institutionalized persons**

    (*select one*):

    - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ( ) **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the State Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

◉ **The following formula is used to determine the needs allowance:**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process which includes income that is placed in a Miller trust.

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable (see instructions)**
○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**
○ **AFDC need standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard

for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

  Specify:

- **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it

determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The DD Division performs the initial level of care evaluation for waiver applicants. Division staff performing the initial level of care evaluation are required to have any combination of training and experience equivalent to a bachelor's degree in business or public administration, social services, psychology, counseling or education, PLUS two years of professional work experience in training, counseling, planning or administering services for persons in a brain injury, developmental disability program or a visually impaired program.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

If a person has medical verification of the an acquired brain injury that is approved by the DD Division, then three tools are used to determine ICF/MR Level of Care for initial applicants: the LT-104 form, a neuropsychological evaluation, and an Inventory for Client and Agency Planning (ICAP) assessment.

LT-104 Form
First, the LT-104 form assesses the individual's qualifying conditions for ICF/MR level of care due to medical or psychological criteria and functional limitations. The LT-104 indicates the person has mental retardation or a developmental disability and may meet the ICF/MR level of care based upon needs in at least two of the following areas:

1) Medical criteria, where the person requires daily monitoring due to his/her medical condition and overall care planning is necessary and/or supervision is needed due to medication effects,

Or the individual meets:

2) Psychological criteria, where the person requires supervision due to impaired judgment, limited capabilities, behavior, abusiveness, assaultiveness, and/or psychotropic drug effects.

After meeting at least one of the criteria (#1 or #2) above, the individual must also have:

3) Functional limitations, where the person requires assistance with activities of daily living, self-help skills, ambulation, mobility, routine incontinence care, catheter care, ostomy, and/or a structured and safe environment that provides supervision as needed to remain safe.

If the individual is determined to meet the criteria on the LT-104 form, then the assessment indicates the individual requires the provision of waiver services monthly to develop skills necessary for maximum independence and/or the prevention of regression or loss of current skills/abilities.

Neuropsychological evaluation
The neuropsychological evaluation shall provide verification that the individual meets ICF/MR level of care through the following:
1) A Mayo Portland Adaptability Inventory (MPAI) score of 42 or more
or
2) A California Verbal Learning Test II Trials 1-5 T score of 40 or less
or
3) Supervision Rating Scale score of 4 or more

ICAP
The Inventory for Client and Agency Planning (ICAP) assessment is completed to measure the severity of the functional limitations for ICF/MR level of care determination. The individual shall have an ICAP service score of 70 or less.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Initial Evaluation:

The DD Division first requires medical verification of an acquired brain injury before assessing the person's level of care. Verification of a brain injury is determined by a licensed physician and registered nurse who reviews the medical documentation submitted by the applicant and verifies that this documentation meets the definition of acquired brain injury as listed below:

Acquired Brain Injury - any combination of focal and diffuse central nervous system dysfunction. Both immediate and/or delayed, at the brain stem level and above. These dysfunctions are acquired through the interaction of any external forces and the body, oxygen deprivation, infection, toxicity, surgery and vascular disorders not associated with aging. It is an injury to the brain that has occurred since birth. It may have been caused by an external physical force or by a metabolic disorder(s). The term acquired brain injury includes traumatic brain injuries such as open or closed head injuries and non traumatic brain injuries such as those caused by strokes, tumors, infectious diseases (e.g. encephalitis or meningitis), hypoxic injuries (e.g. asphyxiation, near drowning, anesthetic incidents, or severe blood loss), metabolic disorders (e.g., insulin shock or liver or kidney disease), and toxic products taken into the body through inhalation or ingestion. The term does not include brain injuries that are congenital or brain injuries induced by birth trauma. These dysfunctions are not developmental or degenerative.

If a person has medical verification of the an acquired brain injury that is approved by the DD Division, then three tools are used to determine ICF/MR Level of Care for initial applicants: the LT-MR-104 form, a neuropsychological evaluation, and an Inventory for Client and Agency Planning (ICAP) assessment.

First, the LT-MR-104 form assesses the individual's qualifying conditions for ICF/MR level of care due to medical or psychological criteria and functional limitations. The LT-MR-104 indicates the person has mental retardation or a developmental disability and may meet the ICF/MR level of care based upon needs in at least two of the following areas:

1) Medical criteria, where the person requires daily monitoring due to his/her medical condition and overall care planning is necessary and/or supervision is needed due to medication effects,

Or the individual meets:

2) Psychological criteria, where the person requires supervision due to impaired judgment, limited capabilities, behavior, abusiveness, assaultiveness, and/or psychotropic drug effects.

After meeting at least one of the criteria (#1 or #2) above, the individual must also have:

3) Functional limitations, where the person requires assistance with activities of daily living, self-help skills, ambulation, mobility, routine incontinence care, catheter care, ostomy, and/or a structured and safe environment that provides supervision as needed to remain safe.

If the individual is determined to meet the criteria on the LT-MR-104 form, then the assessment indicates the individual requires the provision of waiver services monthly to develop skills necessary for maximum independence and/or the prevention of regression or loss of current skills/abilities.

If the individual is determined to meet the criteria above, a neuropsychological evaluation is authorized to be completed by a licensed psychologist, who has at least one year of post doctoral work in acquired brain injury. The neuropsychological evaluation shall provide verification that the individual meets ICF/MR level of care through the following:

1) A Mayo Portland Adaptability Inventory (MPAI) score of 42 or more
or
2) A California Verbal Learning Test II Trials 1-5 T score of 40 or less
or
3) Supervision Rating Scale score of 4 or more

A determination of either #1, 2, or 3 must be found to qualify for ICF/MR level of care and to have the third assessment (ICAP) completed.

If the individual meets one of the conditions in the neuropsychological evaluation, then an Inventory for Client and Agency Planning (ICAP) assessment is completed to measure the severity of the functional limitations for ICF/MR level of care determination. The individual shall have an ICAP service score of 70 or less.

If the individual meets the criteria as verified through these three assessment tools, the DD Division determines that the individual meets ICF/MR Level of Care.

Reevaluation process:

The reevaluation process includes the annual level of care assessment using the LT-104, which determines that the person continues to meet the level of care for the ICF/MR. The other two tools, the neuropsychological evaluation and the ICAP assessment, are completed and evaluated by the DD Division every five years or as needed because of a change in the person's condition. Because an individual's condition and limitations do not change frequently with mental retardation or developmental disability diagnosis, annual neuropsychological evaluations and ICAP assessments are not necessary to determine LOC each year.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

In Chapter 43, Section 9 of the Wyoming Medicaid rules, rules for the Acquired Brain Injury Waiver, the DD Division requires annual submission of level of care assessment and the plan of care from the individual's case manager. These items are required to be submitted 30 days prior to the plan start date, so the DD Division within the State Medicaid Agency can determine level of care based upon recommendations by the case manager before services are authorized.

The DD Division reviews a level of care assessment to assure it meets the eligibility requirements as detailed in B.6.f. and has been completed within the required time frames. Level of care assessments must be completed annually, which is no more than 365 days from the last level of care evaluation date. The case managers' submission of the annual level of care assessment to the DD Division is tracked through the ABI Waiver Access database. A report is generated for the level of care determinations that are due within the next 30 days, which have not been submitted to the DD Division by the case manager. The case manager is notified by the DD Division in writing of the requirement to submit the level of care form within seven (7) business days. Once the level of care form is received, DD Division staff complete the level of care determination and enter the date that the redetermination was completed and the results of the redetermination. In instances, where assessments are not reevaluated within the required time frames, the DD Division tracks the concern and notifies the case manager that an evaluation is needed for continued eligibility. If expired assessments are identified as a concern with a provider, then the DD Division will require a

quality improvement plan from the provider to ensure timeliness of continued eligibility assessments.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Maintenance of these records is required by the providers of case management. The case manager and the DD Division will maintain all documentation relevant to evaluations and reevaluations for a minimum of 6 years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of individuals who present for an ABI Level of Care assessment for whom a Level of Care assessment was completed (the number of LOC assessments completed divided by the number of individuals who present for an LOC)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI application referral database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of individuals who had a Level of Care assessment who were determined to be eligible for ABI waiver services (the number of individuals who met LOC divided by the number of individuals who had an LOC assessment completed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI application referral database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance

measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of ABI Level of Care reassessments conducted within a year of the previous Level of Care assessment (the number of LOC reassessments completed within one year divided by the total number of waiver participants)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver access database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of Level of Care determinations that were based on required assessments in the approved waiver (number of LOC determinations that were based on the required assessments specified in the approved ABI waiver divided by the total number of LOC determinations completed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI Plan of Care excel spreadsheet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of Level of Care forms that require case management correction before Division approval (the number of LOCs requiring case management correction after review by DD Waiver Specialist divided by the total number of LOC determinations)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI Plan of Care excel spreadsheet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

For Subassurance #1:

The level of care assessment is submitted by the case manager for determination by the DD Division after medical verification of the brain injury has been submitted and approved by the DD Division. If a case manager fails to submit the LT-104 within 30 days of medical documentation verification, DD Division staff notifies the case manager of the requirement to submit the information. An application is considered complete once the applicant has completed the application form for the waiver, submitted guardianship papers (if applicable) and has a completed case management selection form signed by the case manager chosen. If the case manager submits an LT-104 form that is incomplete or not accurate, DD Division requires the correction of the form and tracks this information in the Application referral database.

The DD Division tracks the dates of each stage of eligibility in a database and follows up with the case manager if the next steps in eligibility are not taken in according to Division rules. The neuropsychological evaluation is due within 60 days of a case manager being chosen, unless there are problems with finding a psychologist with an appointment available or there is a delay in the report, in which case, an extra 30 days is allotted. After the neuropsychological evaluation is approved by the DD Division, the ICAP assessment shall be completed within 30 days of the request being submitted to the contractor. If the ICAP is not completed according to the timeframe specified in the contract, the DD Division follows up with the contractor to ensure timeliness in subsequent assessments completed.

The DD Division determines level of care based on the three assessments and tracks the determination in the Application referral database, so the number of level of care determinations and results of the determinations can be quantified.

For Subassurance #2:

A report is generated for the level of care redeterminations due within the next 30 days that have not been submitted to the DD Division by the case manager. The case manager is notified by the DD Division in writing of the requirement to submit the level of care form, if there is a lapse in the LOC due date. If late submissions continue to be a problem with a certain case manager, then a quality improvement plan will be put in place with the case manager to address the issue as a certification concern.

When case managers submit level of care assessments for approval by the DD Division that are incomplete or inaccurate, they are required to correct it and resubmit it to the DD Division. If problems with the LOC form persist, the DD Division will track the problem as a certification issue and retrain the case manager on the level of care tool to address the problem. The case manager may also be required to complete a Quality Improvement Plan as described in Appendix G.

For Subassurance #3:

The level of care assessment submitted to the DD Division by the case manager is accompanied with required assessments listed in the waiver, which are the psychological evaluation and the ICAP assessment. If the psychological evaluation or ICAP assessment dates are outside the required timeframe, the case manager is immediately notified and testing is scheduled. If a participant is determined by the DD Division to not meet ICF/MR Level Of Care or becomes ineligible because of one the required assessments, then an adverse action letter will be sent to the participant and case manager to notify them of the denial of eligibility of the waiver and the participant's right to a fair hearing.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DD Division staff contact each ABI Waiver applicant in person or by telephone to explain the application process and to provide information on both the ABI Waiver and institutional services available so the applicant can make an informed choice of institution or community based services. If DD Division staff are able to meet with the applicant in person the applicant is also given the DD Division's application guide and self-direction handbook. If DD Division staff are unable to meet with the applicant in person, this information is provided over the phone and the information is mailed to the applicant, along with DD Division contact information. The Application guide includes written information stating the applicant has a choice of waiver or institutional services. Applicants sign the application stating they understand they have a choice of institutional or community based services.

After completing the application the applicant chooses a case manager who coordinates completion of the assessments needed to determine the person meets the targeting criteria and ICF/MR level of care. Once the applicant is determined to meet the targeting criteria and ICF/MR level of care, he or she can choose to receive services in the institution or on the ABI Waiver. If the applicant chooses the institution, the case manager assists the applicant in completing the process for applying at the institution.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

This is a component part of case management. The case manager and the DD Division will maintain all freedom of choice forms for a minimum of 6 years.

Appendix B: Participant Access and Eligibility

D-3: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The DD Division utilizes an interpreter service also utilized by the State Medicaid Agent for other medicaid beneficiaries. Case Managers complete a form to request interpreter services, to specify the language, type of material and the manner it needs interpreted (written or verbal). Individual Plans of Care can be translated into another language upon request. If there is a significant number of beneficiaries requesting written materials in a language different than English, the DD Division will contract to have printed materials in different languages.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Case Management
Statutory Service	Community Integrated Employment
Statutory Service	Day Habilitation
Statutory Service	Homemaker
Statutory Service	Personal Care
Statutory Service	Prevocational Services - phased out Year 1
Statutory Service	Residential Habilitation
Statutory Service	Respite
Statutory Service	Supported Living
Extended State Plan Service	Occupational Therapy
Extended State Plan Service	Physical Therapy
Extended State Plan Service	Speech Therapy
Supports for Participant Direction	Agency with Choice
Supports for Participant Direction	Independent Support Broker
Other Service	Cognitive Retraining
Other Service	Companion Services
Other Service	Dietician Services
Other Service	Environmental Modifications
Other Service	In Home Support - phased out Year 1
Other Service	Individually-Directed Goods and Services
Other Service	Skilled Nursing
Other Service	Specialized Equipment
Other Service	Unpaid Caregiver Training and Education

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Service Definition *(Scope):*

Case management is a service to assist participants in gaining access to needed waiver and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers are responsible for the following functions for participants choosing not to self-direct services:
- Assessment and/or reassessment of the need for waiver services;
- Initiating the process to evaluate and/or re-evaluate the individual's level of care
- Linking waiver participants to other Federal, state and local programs;
- Developing the plan of care according to the DD Division's policies and procedures;
- Coordinating multiple services and/or among multiple providers;
- Ongoing monitoring of the implementation of the plans of care;
- Ongoing monitoring of participant's health and welfare;
- Addressing problems in service provision, including problems found during the ongoing monitoring of the implementation of the plan of care or concerns with a participant's health and welfare;
- Responding to participant crises;
- Reviewing service utilization and documentation of all services provided on a monthly basis to assure the amount, frequency, and duration of services are appropriate.

The case manager is required to complete the following responsibilities monthly:
- A home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.
- Direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means.
- Follow-up on all concerns or questions raised by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.
- Review of service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use of restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and complete follow-up on concerns identified in any of these processes.

Subsequent assessments are provided as part of ongoing case management and will include the necessary collaboration of professionals to assess the needs, characteristics, preferences and desires of the waiver participant. Case managers shall initiate and oversee subsequent assessments, regardless of payment source. These include the psychological assessment, which is required for continued eligibility, and any other assessments that are necessary to determine the participant's needs and are not available through the Medicaid State plan. All assessments shall be prior authorized by the Division.

Case Managers are responsible for the following functions for participants who choose to self-direct services:
- Assessment and/or reassessment of the need for waiver services;
- Initiating the process to evaluate and/or re-evaluate the individual's level of care
- Working with the participant, Support Broker and other team members on development of the plan of care that addresses the participant's needs, and submission of the plan of care to the DD Division adhering to the DD Division's policies and procedures;
- Ongoing monitoring of the implementation of the plan of care, including monitoring self-directed services and traditional services;
- Ongoing monitoring of participants' health and welfare;
- Addressing problems in service provision, including problems found during the ongoing monitoring of the implementation of the plan of care or concerns with a participant's health and welfare, working with the participant, Support Broker and plan of care team members as appropriate;
- Responding to participant crises;
- Reviewing service utilization and documentation of all services provided on a monthly basis, including all self-

directed services, to assure the amount, frequency, and duration of services are appropriate.

The role of the Case Manager is to monitor the implementation of the individual plan of care and provide coordination and oversight of supports but not "hands on" involvement in identifying and securing supports. Those are duties of the Support Broker.

The case manager is required to complete the following monthly:
• A home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.
• Direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means.
• Follow-up on all concerns or questions raised by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.
• Review of service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use of restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and complete follow-up on concerns identified in any of these processes.

Some participants self-directing services may choose not to have a Support Broker after the first year. This may be because they are skilled enough to complete those tasks themselves (as determined through assessment) or they have natural supports that can assist them. In these cases, the general oversight responsibilities of the case manager shall be sufficient to monitor the participant's self-direction efforts.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Case Managers shall be reimbursed up to 1 unit per month and shall provide a minimum of 2 hours of documented case management service and have completed a home visit each month in order to bill. Service time may consist of direct participant contact, guardian contact, phone calls to the participant or guardian, monitoring the participant in services, following up on concerns or questions regarding the particpant, team meetings, plan of care development or updating, the monthly home visit, and service documentation review.

A parent, legally responsible person, or guardian may provide case management services to their ward if they meet all the provider requirements and complete the process to become a certified Waiver Medicaid Waiver case manager, including signing a Medicaid provider agreement. Wyoming state law does not permit parents or legally responsible persons to be reimbursed for services provided to their ward but the parent or legally responsible person may provide the service in accordance with the case manager requirements with no pay. However, they can be reimbursed for case management services they provide to other Waiver participants, who have chosen them to provide these services.

Case management services on the waiver can only be billed and reimbursed after the plan of care is approved by the DD Division. Prior to entrance to the waiver, targeted case management services are reimbursed through the Medicaid State Plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified to provide case management
Agency	CARF-accredited agency certified to provide case management services
Individual	individual certified to provide case management services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency certified to provide case management

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies certified to provide case management services must verify case management staff have a minimum of a Bachelors degree and ½ year of experience working with individuals with acquired brain injury (ABI) or an Associate's degree and two years of experience working with individuals with ABI or equivalent training and experience in ABI. Case management staff must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Case managers are required to complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Case managers are required to facilitate team meetings, complete and submit the individual plan of care to the DD Division for approval, and monitor the implementation of the individual plan of care, including health and safety, progress on objectives, satisfaction with services, and appropriateness and quality of services being provided, per Developmental Disabilities Division rules, Chapter 1. All agencies that are certified to provide case management services are required to obtain an NPI number specific to case management services. In addition, all case managers employed with the organization are also required to have an NPI number specific to case management. These case managers are referred to as the treating provider for billing purposes and bill for case management services under their individual NPI numbers, which are linked to the organization's case management NPI number. The organization receives payment for case management services as the pay-to provider. For any other waiver services on the plan, the organization is required to bill using their original NPI number.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing case management for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency certified for up to two years. Agencies certified to provide case management who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the case manager is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

CARF-accredited agency certified to provide case management services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires agencies certified to provide case management services who are also serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Case managers must have a minimum of a Bachelors, Master's or Doctoral degree and ½ year of experience working with individuals with acquired brain injury (ABI) OR two years (48 credit hours) of college credit and two years of experience working with individuals with ABI or equivalent training and experience in ABI. Case Managers must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Case managers are required to complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, self-directed services, and HIPAA & Confidentiality requirements. Case managers are required to facilitate team meetings, complete and submit the individual plan of care to the DD Division for approval, and monitor the implementation of the individual plan of care, including health and safety, progress on objectives, satisfaction with services, and appropriateness and quality of services being provided, per Developmental Disabilities Division rules, Chapter 1. Case Managers must adhere to Chapter 1 of the Developmental Disabilities Division rules, and Chapters 41 through 45 of the Wyoming Medicaid rules. All agencies that are certified to provide case management services are required to obtain an NPI number specific to case management services. In addition, all case managers employed with the agency are also required to have an NPI number specific to case management. These case managers are referred to as the treating provider for billing purposes and bill for case management services under their individual NPI numbers, which are linked to the organization's case management NPI number. The organization receives payment for case management services as the pay-to provider. For any other waiver services on the plan, the organization is required to bill using their original NPI number.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency certified to provide case management for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and

regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies certified to provide case management services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the case manager is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Individual
Provider Type:
individual certified to provide case management services
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individuals certified to provide case management services must have a minimum of a Bachelors degree and ½ year of experience working with individuals with acquired brain injury (ABI) or an Associate's degree and two years of experience working with individuals with ABI or equivalent training and experience in ABI. Individuals certified to provide case management services must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide case management services are required to complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Individuals certified to provide case management services are required to facilitate team meetings, complete and submit the individual plan of care to the Division for approval, and monitor the implementation of the individual plan of care, including health and safety, progress on objectives, satisfaction with services, and appropriateness and quality of services being provided, per Developmental Disabilities Division rules, Chapter 1.

Case Managers must adhere to Chapter 1 of the Developmental Disabilities Division rules, and Chapters 41 through 45 of the Wyoming Medicaid rules. Independent case managers, who are not employed with an organization and provide other waiver services to a participant in addition to case management, are required to bill for case management using his/her NPI number and bill for all other waiver services using the original provider billing number (known as a Wyoming number).

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
Individuals certified to provide case management services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide case management services can be recertified for up to two years. Individuals certified to provide case management services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation

receive up to a one year recertification, and individuals certified to provide case management services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide case management services throughout their recertification period through the DD Division's complaint process, incident reporting process, or the DD Division's internal referral process. The DD Division has the authority to monitor case managers throughout their recertification period through the DD Division's complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Community Integrated Employment

Service Definition *(Scope):*

Supported Employment Services may be provided as a 1:1 service under Individual Community Integrated Employment services or under a group rate under Group Supported Employment Services.

Supported Employment Services, provided as Individual Community Integrated Employment services or Group Supported Employment Services consist of intensive, ongoing support that enable a participant, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of his/her disability, need supports to perform in a regular work setting. Services may include assisting the participant to locate a job or develop a job on behalf of the participant. Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Services include activities needed to sustain paid work by a participant, including supervision and training. When Supported Employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Objectives must be identified in the participant's plan that support the need for continued job coaching. The job coach must be in the immediate vicinity and available for immediate intervention and support. Transportation is included in the reimbursement rate.

Group Supported employment can include employment in community businesses or businesses that are part of a provider organization. Individual Community Integrated Employment Services must be provided in a community employment setting.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an participant's supported employment program.

Transportation is included in the reimbursement rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The service can only be used if a similar service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Services for waiver participants age 21 cannot be provided during local school district hours.
Federal financial participation shall not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an participant's supported employment program.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF Accredited agency certified to provide supported employment services
Agency	Agency certified to provide supported employment services
Individual	Individual hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Integrated Employment

Provider Category:
Agency
Provider Type:
CARF Accredited agency certified to provide supported employment services
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The DD Division requires providers certified to provide supported employment services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.
Other Standard *(specify):*
Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing supported employment services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA &

Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest. Agencies must also meet the applicable Medicaid rules and regulations, including assuring participants are involved in making informed employment related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on employment services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency providing supported employment services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Integrated Employment

Provider Category:

Agency

Provider Type:

Agency certified to provide supported employment services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing supported employment services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing support employment services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post

emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest. Agencies must also meet the applicable Medicaid rules and regulations, including assuring participants are involved in making informed employment related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities, and participants' satisfaction with employment services is assessed on a regular basis.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing supported employment services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Integrated Employment

Provider Category:

Individual

Provider Type:

Individual hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Fiscal/Employer Agent FMS or Agency with Choice FMS verifies that the individual being hired:

- Is at least 18 yrs of age
- Has completed a successful criminal background check
- Has completed a successful Central Registry check
- Has the ability to communicate effectively with the individual/family
- Has the ability to complete record keeping as required by the employer
- Has current CPR and First Aid Certification
- Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker, verifies that, prior to working alone with the participant, the individual being hired:

- Demonstrates competence in knowledge of the following DD Division policies and procedures: recognizing abuse/neglect; incident reporting; participant rights and confidentiality; emergency drills/situations,

• Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal/Employer Agent FMS or Agency with Choice FMS

Frequency of Verification:

Supported Employment providers employed under the Financial Management Service are required to show evidence of a successful Central Abuse Registry Screening, a successful Criminal History Background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current CPI or MANDT certification (if applicable) prior to being employed and providing waiver services.

Upon employment, supported employment providers are required to maintain current CPR and First Aid certification, CPI or MANDT (if applicable), and current driver's license and vehicle insurance (if transporting participants). If the DD Division receives notification that the provider has been charged with an offense that would list them on the Central Registry or has been charged with an offense listed in Chapter 45, Section 25 of Medicaid Rules, then the provider shall immediately complete and show evidence of a successful Central Registry check or a Criminal History Background check prior to being allowed to continue being employed and providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. In addition, any documentation that has an expiration date such as CPR and First Aid are entered into their database as to the date of when it expires.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent - FMS database is updated and the FMS allows the employee to start work. Fiscal Employer Agent - FMS also does quarterly reviews on a random sample of files to ensure that documents are in and marked correctly. The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers.

With assistance from the support broker, the participant will take on the responsibility and provide additional oversight in ensuring that all employees are current on all required certifications that have an expiration date such as CPR, First Aid, and Medication Assistance. After the first year of self-direction, before the participant will be allowed to "opt out" of having a support broker, the Division will ensure that the participant and/or their legal representative understands their oversight responsibility in ensuring all providers are current in required certifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Service Definition *(Scope):*

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished four (4) or more hours per day on a regularly

scheduled basis for one (1) or more days per week or as specified in the participant's service plan. Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings.

Individuals in Day Habilitation may be paid for work activities if the focus of the activity is not independent employment but a means to encourage acquisition, retention, or improvement of skills. If an organization is paying less than minimum wage, all wage and hour labor laws will be met.

All transportation including trips to and from the residence, therapy, volunteer sites, and any community activities will be included in the rate.

Day Habilitation Intervention can be added to a plan for situations where a participant's supervision level may not provide sufficient staffing for specific activities, but the extensive supervision is not needed at all times. Intervention provides an extra staff person to supervise a participant during times of behavioral episodes, extensive personal care, positioning, health, medical, or safety needs. Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of teaching appropriate behaviors and keeping the participant safe.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The plan of care must identify either the daily unit or the 15 minute unit based on the participant's need. The daily unit requires a minimum of four (4) hours a day of service and assumes five (5) units per week. Units will be based on individual need with the maximum of 15-minute units being 3750 units in a plan year.

Day habilitation services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified to provide day habilitation services
Agency	CARF Accredited agency certified to provide day habilitation services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Agency certified to provide day habilitation services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing day habilitation services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing day habilitation services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new agency providing day habilitation services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency

Provider Type:
CARF Accredited agency certified to provide day habilitation services

Provider Qualifications

License *(specify):*

Certificate *(specify):*
The DD Division requires providers certified to provide day habilitation services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*
Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing day habilitation services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document

participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on day habilitation services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies agencies providing day habilitation services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Service Definition *(Scope):*

Services consisting of general household activities such as meal preparation and routine household care, which are provided by a trained homemaker when the individual regularly responsible for these activities is unable to manage the home and care for himself/herself or others in the home or when the person who usually does these things is temporarily unavailable or unable to perform the tasks. This service does not include direct care/supervision of the waiver participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Plan limit is 156 hours, with a maximum of 3 hours per week per household.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-accredited agency certified to provide homemaker services
Agency	Agency certified to provide homemaker services
Individual	Individual certified to provide homemaker services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
CARF-accredited agency certified to provide homemaker services
Provider Qualifications
License *(specify):*

Certificate *(specify):*
CARF-accredited agencies providing homemaker services that are also providing residential habilitation services or day habilitation services to three or more participants are required to obtain and maintain CARF accreditation per Wyoming Medicaid rules, Chapter 45, Section 21.
Other Standard *(specify):*
Providers must meet all applicable CARF standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports.

In addition, pursuant to Chapter 45, Section 11, agencies must obtain and show evidence that individual staff providing homemaker services are 18 years of age or older and have completed a successful background check and Central Registry Screening. Staff providing this service must have documentation that they have received training on recognizing and reporting abuse, neglect and exploitation, the DD Division's Notification of Incident process, billing and documentation, releases of information and HIPAA/confidentiality, and the grievance/complaint procedure.

Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing homemaker services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Agency certified to provide homemaker services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Per Wyoming Medicaid rules, Chapter 45, Section 11 an agency providing homemaking services must obtain and show evidence that individual staff providing homemaking services to participants are 18 years of age or older and have completed a successful background check and Central Registry screening. Staff providing this service must have documentation that they have received training on recognizing and reporting abuse, neglect, and exploitation, the Division's Notification of Incident process, billing and documentation, releases of information and confidentiality, and the grievance/complaint procedure.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing homemaker services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Individual certified to provide homemaker services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Per Wyoming Medicaid rules, Chapter 45, Section 11, an individual providing homemaker services must be 18 years of age or older and must complete Division required background screenings and Central Registry screenings. Each homemaker provider must have documentation that they have received training on recognizing and reporting abuse, neglect, and exploitation, the DD Division's Notification of Incident process, billing and documentation, releases of information and confidentiality, recertification, and the grievance/complaint procedure.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies an individual providing homemaker services for one year and the individual is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an individual for up to two years. Individuals who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor individuals throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the individual is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):

Service Definition *(Scope):*
A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include nursing care and medication administration to the extent permitted by State law.

Such assistance may include assistance in performing activities of daily living (ADLs-bathing dressing, toileting, transferring, maintaining continence) and instrumental activities of daily living on the person's property (IADLs-more complex life activities, e.g. personal hygiene, light housework, laundry, meal preparation exclusive of the cost of the meal, using the telephone, medication and money management). Transportation costs are not included as part of this service.

The participant must be physically present. Personal care shall be provided in the participant's home or on their property. If the individual providing this service is not employed and supervised by an agency, then the participant is responsible for supervising the individual and may coordinate monitoring of the service with his/her case manager.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service cap is 7280 units. This is a 1:1 service based on individual needs. Service is billed in 15-minute units. Personal care is available to participants of all ages. Personal care services are included in Companion, Supported Living, and Residential Habilitation services; therefore, Personal Care cannot be provided in conjunction with those services on the same plan. Personal care cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Personal care is not covered as a stand-alone service through the state plan. It can be provided through home health only. A home health provider typically provides services from 8 am to 5 pm. Being a rural state, many Wyoming communities do not have home health providers to serve their community. Those that do, often do not have enough employees to meet the extensive needs of some waiver participants. Waiver participants who need personal care services must utilize providers that can provide the type, amount and flexible hours of services deemed most appropriate for the participant. The waiver service allows the team to find and utilize providers who can best meet the participant's needs.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual chosen by the participant
Agency	Home Health Agency certified to provide personal care
Agency	CARF Accredited agency certified to provide personal care services
Agency	Agency certified to provide personal care services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Individual
Provider Type:
Individual chosen by the participant
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The Fiscal/Employer Agent FMS or Agency with Choice FMS verifies that the individual being hired:

- Is at least 18 yrs of age
- Has completed a successful criminal background check

• Has completed a successful Central Registry check
• Has the ability to communicate effectively with the individual/family
• Has the ability to complete record keeping as required by the employer
• Has current CPR and First Aid Certification

The participant and/or legal representative, with assistance as needed from the Support Broker, verifies that, prior to working alone with the participant, the individual being hired:

• Demonstrates competence in knowledge of the following DD Division policies and procedures: recognizing abuse/neglect; incident reporting; participant rights and confidentiality; emergency drills/situations,
• Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal/Employer Agent FMS or Agency with Choice FMS provider

Frequency of Verification:
Personal care providers employed under the Financial Management Service are required to show evidence of a successful Central Abuse Registry Screening, a successful Criminal History Background, current CPR and First Aid certification, and current CPI or MANDT certification (if applicable) prior to being employed and providing waiver services.

Upon employment, personal care providers are required to maintain current CPR and First Aid certification, CPI or MANDT (if applicable). If the DD Division receives notification that the provider has been charged with an offense that would list them on the Central Registry or has been charged with an offense listed in Chapter 45, Section 25 of Medicaid Rules, then the provider shall immediately complete and show evidence of a successful Central Registry check or a Criminal History Background check prior to being allowed to continue being employed and providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. In addition, any documentation that has an expiration date such as CPR and First Aid are entered into their database as to the date of when it expires.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent - FMS database is updated and the FMS allows the employee to start work. Fiscal Employer Agent - FMS also does quarterly reviews on a random sample of files to ensure that documents are in and marked correctly. The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers.

With assistance from the support broker, the participant will take on the responsibility and provide additional oversight in ensuring that all employees are current on all required certifications that have an expiration date such as CPR, First Aid, and Medication Assistance. After the first year of self-direction, before the participant will be allowed to "opt out" of having a support broker, the Division will ensure that the participant and/or their legal representative understands their oversight responsibility in ensuring all providers are current in required certifications.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency

Provider Type:
Home Health Agency certified to provide personal care

Provider Qualifications

License *(specify):*

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.

Certificate *(specify):*

Other Standard *(specify):*

Home Health Agencies providing personal care services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 23, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing personal care services upon hire, maintaining current CPR and First Aid Certification for all direct care staff. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must adhere to documentation standards and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new home health agency providing personal care services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide personal care services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires agencies certified to provide personal care services who are also serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 21 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Providers must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports.

In addition, pursuant to Chapter 45, Section 21, all staff providing personal care services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, and maintain current CPR and First Aid Certification. In addition, agencies must meet the requirements pursuant to Chapter 45 of Wyoming Medicaid Rules. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency providing personal care services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Agency certified to provide personal care services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing personal care services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 23, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing personal care services upon hire, maintaining current CPR and First Aid Certification for all direct care staff. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and

HIPAA & Confidentiality requirements. Agencies must adhere to documentation standards and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new agency providing personal care services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Prevocational Services

Alternate Service Title (if any):
Prevocational Services - phased out Year 1

Service Definition *(Scope):*
Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). When compensated, individuals are paid at less than 50 percent of the minimum wage.
Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the participant's plan of care as directed to habilitative, rather than explicit employment objectives.
Documentation will be maintained in the file of each individual receiving this service that:
Prevocational services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).
The Wyoming Division of Vocational Rehabilitation do not provide funding for pre-vocational services, therefore funding opportunities are not otherwise available.

This service will be phased out in Year 1 of the waiver renewal.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF Accredited agency certified to provide prevocational services
Agency	Agency certified to provide prevocational services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services - phased out Year 1

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide prevocational services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires providers certified to provide prevocational services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing prevocational services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Agency staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Agencies must also meet the applicable Medicaid rules and regulations, including assuring participants are involved in making informed employment related decisions, participants are linked to services and community resources that enable them to achieve their employment objectives, participants are given information on local job opportunities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services - phased out Year 1

Provider Category:

Agency

Provider Type:

Agency certified to provide prevocational services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing prevocational services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing prevocational services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing prevocational services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency certified for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Service Definition *(Scope):*

Individually-tailored supports for a waiver participant that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care, protective oversight and supervision.
Residential habilitation may be furnished in a home owned or leased by a provider or in the participant's home, where staff provides on-going 24 hour supervision. Provider owned or leased facilities where residential habilitation services are furnished must be compliant with the Americans with Disabilities Act.
Transportation between the participant's place of residence, other service sites, or places in the community is included in the rate.
Payment is not made, directly or indirectly, to members of the participant's immediate family, except as provided in Appendix C-2. Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5.

Residential Habilitation Intervention can be added to a plan for situations where a participant's supervision level may not provide sufficient staffing for specific activities, but the extensive supervision is not needed at all times. Intervention provides an extra staff person to supervise a participant during times of behavioral episodes, extensive personal care, positioning, health, medical, or safety needs. Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of teaching appropriate behaviors and keeping the participant safe.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The provision of residential habilitation services includes personal care needs, so plans of care are not approved that include both residential services and personal care services. The participant must be in service a minimum of 8 hours in a 24 hour period (from 12:00am-11:59pm) for the provider to be reimbursed. Family visits and trips are encouraged. The provider will be allowed to be reimbursed on the day the participant returns home from a trip.

Waiver participants who are not receiving 24-hour residential services but are at significant risk due to extraordinary needs that cannot be met in their current living arrangement may request 24-hour Residential Habilitation services if the participant meets one of the following targeting criteria:

• A substantial threat to a person's life or health caused by homelessness or abuse/neglect that is either substantiated by Department of Family Services or corroborated by the Developmental Disabilities Division or Protection & Advocacy Systems, Inc.
• Situations where the person's condition poses a substantial threat to a person's life or health, and is documented in writing by a physician.
• Situations where a person has caused serious physical harm to him or herself or someone else in the home, or the person's condition presents a substantial risk of physical threat to him or herself or others in the home.
• Situations where there are significant and frequently occurring behavior challenges resulting in danger to the person's health and safety, or the health and safety of others in the home.
• Situations where the person's critical medical condition requires ongoing 24-hour support and supervision to maintain the person's health and safety.

• Loss of primary caregiver due to caregiver's death, incapacitation, critical medical condition, or inability to provide continuous care.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified to provide residential habilitation services
Agency	CARF Accredited agency certified to provide residential habilitation services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Agency certified to provide residential habilitation services
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing residential habilitation services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing residential habilitation services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing residential habilitation services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to

health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide residential habilitation services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires providers certified to provide Residential Habilitation Services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing residential habilitation services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency certified to provide residential habilitation services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to

a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Service Definition *(Scope):*

Respite care consists of services provided to participants unable to care for themselves. Respite is intended to be utilized on a short-term basis because of the absence or need for relief of the natural caregiver. Respite must be episodic, for special events when the caregiver needs relief. Respite cannot be used as a substitute for care while the primary caregiver is at work. It cannot be used for daily scheduled supervision. The amount of Respite services authorized shall be based upon need and cannot be provided during local school district hours for waiver participants age 21.

Respite care may be provided in the waiver participant's home, the private residence of a Respite care provider, or in a group home, as long as the staff person in the group home does not have supervision duties to others living in the group home. Respite services shall not cover any cost for room and board.

Respite care may include activities that take place in community settings such as parks, stores, recreation centers.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service is a 15 minute unit with a limit based upon the participant's need and budget limit, not to exceed 7,280 units per plan year if living with family and not to exceed 2500 units per plan if living in residential services with a non-CARF accredited provider. Services provided must be provided as relief of the primary care giver, should primarily be episodic in nature, and not used when parents or unpaid primary caregivers are working. Respite can only be provided to two participants at the same time unless a participant's plan of care requires 1:1 support. Respite services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency certified to provide respite services
Agency	CARF Accredited agency certified to provide respite services
Agency	Agency certified to provide respite services
Individual	Individuals hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Health Agency certified to provide respite services
Provider Qualifications
License *(specify):*
Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.
Certificate *(specify):*

Other Standard *(specify):*
Home Health Agencies providing respite services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing respite services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new home health agency providing respite services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies providing respite services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide respite services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires providers certified to provide respite services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing respite services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency certified to provide respite services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency certified to provide respite services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies providing respite services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing respite services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing respite services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individuals hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The Fiscal/Employer Agent FMS or Agency with Choice FMS verifies that the individual being hired:

• Is at least 18 yrs of age
• Has completed a successful criminal background check
• Has completed a successful Central Registry check
• Has the ability to communicate effectively with the individual/family
• Has the ability to complete record keeping as required by the employer
• Has current CPR and 1st Aid Certification
• Has a current driver's license and automobile insurance if transporting the participant

The participant and/or legal representative, with assistance as needed from the Support Broker, verifies that, prior to working alone with the participant, the individual being hired:

• Demonstrates competence in knowledge of the following DD Division policies and procedures: recognizing abuse/neglect; incident reporting; participant rights and confidentiality; emergency drills/situations,
• Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal/Employer Agent FMS or Agency with Choice FMS

Frequency of Verification:
Respite care providers employed under the Financial Management Service are required to show evidence of a successful Central Abuse Registry Screening, a successful Criminal History Background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current CPI or MANDT certification (if applicable) prior to being employed and providing waiver services.

Upon employment, respite care providers are required to maintain current CPR and First Aid certification, CPI or MANDT (if applicable), and current driver's license and vehicle insurance (if transporting participants). If the DD Division receives notification that the provider has been charged with an offense that would list them on the Central Registry or has been charged with an offense listed in Chapter 45, Section 25 of Medicaid Rules, then the provider shall immediately complete and show evidence of a successful Central Registry check or a Criminal History Background check prior to being allowed to continue being employed and providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. In addition, any documentation that has an expiration date such as CPR and First Aid are entered into their database as to the date of when it expires.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent - FMS database is updated and the FMS allows the employee to start work. Fiscal Employer Agent - FMS also does quarterly reviews on a random sample of files to ensure that documents are in and marked correctly. The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers.

With assistance from the support broker, the participant will take on the responsibility and provide additional oversight in ensuring that all employees are current on all required certifications that have an expiration date such as CPR, First Aid, and Medication Assistance. After the first year of self-direction, before the participant will be allowed to "opt out" of having a support broker, the Division will ensure that the participant and/or their legal representative understands their oversight responsibility in ensuring all providers are current in required certifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Supported Living

Service Definition *(Scope):*

Supported Living Services assist persons with disabilities to live in their own home, family home, or rental unit. These individuals do not require ongoing 24-hour supervision but do require a range of community-based support to maintain their independence. They require individually-tailored supports to assist with the acquisition, retention, or improvement in skills related to living successfully in the community.

Supported living services shall be based upon need. These services can include: assisting with common daily living activities; performing routine household activities to maintain a clean and safe home; assistance with health issues, medications, and medical services; teaching the use of the community's transportation system; teaching the use of police, fire and emergency assistance; managing personal financial affairs; building and maintaining interpersonal relationships; participating in community life; and 24-hour emergency assistance. This service includes personal care, therefore personal care services cannot be added as a separate service on the plan of care.

Transportation is included in the reimbursement rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The plan of care must identify either the daily unit or the 15 minute unit based on the participant's need. The daily unit requires a minimum of 4 hours a day of services and can be reimbursed to up to three participants. The maximum of 15 minute units will be 5400 units in a plan year for the group rate and 3900 units for the individual rate.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF Accredited agency certified to provide Supported Living Services
Agency	Agency certified to provide supported living services
Individual	Individual hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Living

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide Supported Living Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires providers certified to provide supported living services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing supported living services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on employment services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency providing supported living services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Living

Provider Category:

Agency

Provider Type:
Agency certified to provide supported living services
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing supported living services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing supported living services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing supported living services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Living

Provider Category:
Individual
Provider Type:
Individual hired by the participant
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The Fiscal/Employer Agent FMS or Agency with Choice FMS verifies that the individual being hired • Is at least 18 yrs of age • Has completed a successful criminal background check • Has completed a successful Central Registry check • Has the ability to communicate effectively with the individual/family • Has the ability to complete record keeping as required by the employer • Has current CPR and First Aid Certification • Has a current driver's license and automobile insurance if transporting the participant The participant and/or legal representative, with assistance as needed from the Support Broker, verifies that, prior to working alone with the participant, the individual being hired: • Demonstrates competence in knowledge of the following DD Division policies and procedures: recognizing abuse/neglect; incident reporting; participant rights and confidentiality; emergency drills/situations, • Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal/Employer Agent FMS or Agency with Choice FMS

Frequency of Verification:
Supported living providers employed under the Financial Management Service are required to show evidence of a successful Central Abuse Registry Screening, a successful Criminal History Background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current CPI or MANDT certification (if applicable) prior to being employed and providing waiver services.

Upon employment, supported living providers are required to maintain current CPR and First Aid certification, CPI or MANDT (if applicable), and current driver's license and vehicle insurance (if transporting participants). If the Division receives notification that the provider has been charged with an offense that would list them on the Central Registry or has been charged with an offense listed in Chapter 45, section 25 of Medicaid Rules, then the provider shall immediately complete and show evidence of a successful Central Registry check or a Criminal History Background check prior to being allowed to continue being employed and providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. In addition, any documentation that has an expiration date such as CPR and First Aid are entered into their database as to the date of when it expires.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent - FMS database is updated and the FMS allows the employee to start work. Fiscal Employer Agent - FMS also does quarterly reviews on a random sample of files to ensure that documents are in and marked correctly. The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers.

With assistance from the support broker, the participant will take on the responsibility and provide additional oversight in ensuring that all employees are current on all required certifications that have an expiration date such as CPR, First Aid, and Medication Assistance. After the first year of self-direction, before the participant will be allowed to "opt out" of having a support broker, the Division will ensure that the participant and/or their legal representative understands their oversight responsibility in ensuring all providers are current in required certifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:
Occupational Therapy
Service Definition *(Scope):*
Occupational Therapy services consist of the full range of activities provided by a licensed occupational therapist. Services include assessing needs, development a treatment plan, determining therapeutic intervention, training and assisting with adaptive aids. Occupational Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. State Plan Occupational Services are limited to restorative therapy.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	individual certified to provide occupational therapy services
Agency	Home Health Agency certified to provide occupational therapy services
Agency	Agency certified to provide occupational therapy services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual
Provider Type:
individual certified to provide occupational therapy services
Provider Qualifications
License *(specify):*
Individuals certified to provide occupational therapy services must have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy per Wyoming Medicaid Rules, Chapter 45, Section 13.
Certificate *(specify):*

Other Standard *(specify):*
In addition to having a current license to practice occupational therapy, occupational therapists are required to complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Occupational therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights

restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Individuals certified to provide occupational therapy services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide occupational therapy services can be recertified for up to two years. Individuals certified to provide occupational therapy services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide occupational therapy services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide occupational therapy services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency

Provider Type:
Home Health Agency certified to provide occupational therapy services

Provider Qualifications

License *(specify):*
Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.
Home Health Agencies providing occupational therapy services must assure individuals providing the service have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy per Wyoming Medicaid Rules, Chapter 45, Section 13.

Certificate *(specify):*

Other Standard *(specify):*
Home Health Agencies providing occupational therapy services must assure occupational therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Occupational therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new home health agency providing occupational therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency providing occupational therapy services for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies certified to provide occupational therapy services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
Agency certified to provide occupational therapy services
Provider Qualifications

License *(specify):*
Agencies providing occupational therapy services must assure individuals providing the service have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy per Wyoming Medicaid Rules, Chapter 45, Section 13.

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing occupational therapy services must assure occupational therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Occupational therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing occupational therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Extended State Plan Service

Service Title:
Physical Therapy
Service Definition *(Scope):*
Physical Therapy services consist of the full range of activities provided by a licensed physical therapist. This service assists individuals to preserve and improve their abilities for independent function such as range of motion, strength, tolerance, and coordination. It may also prevent, insofar as possible, irreducible or progressive disabilities through the use of assistive and adaptive devices, positioning, and sensory stimulation. Physical Therapy Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. State Plan Physical Services are limited to restorative therapy.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	agency certified to provide physical therapy services
Individual	individual certified to provide physical therapy services
Agency	Home Health Agency certified to provide physical therapy services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
agency certified to provide physical therapy services
Provider Qualifications

License *(specify):*
Agencies providing physical therapy services must assure physical therapists have a current license to practice physical therapy by the Wyoming Board of Physical Therapy per Wyoming Medicaid Rules, Chapter 45, Section 15.
Certificate *(specify):*

Other Standard *(specify):*
Agencies providing physical therapy services must assure physical therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Physical therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on

recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new agency providing physical therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The Division has the authority to monitor providers throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

individual certified to provide physical therapy services

Provider Qualifications

License *(specify):*

Individuals certified to provide physical therapy services must have a current license to practice physical therapy by the Wyoming Board of Physical Therapy per Wyoming Medicaid Rules, Chapter 45, Section 15.

Certificate *(specify):*

Other Standard *(specify):*

In addition to having a current license to practice physical therapy, physical therapists are required to complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Physical therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide physical therapy services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide physical therapy services can be recertified for up to two years. Individuals certified to provide physical therapy services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide physical therapy services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor individuals certified to provide physical therapy services throughout their

recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency certified to provide physical therapy services

Provider Qualifications

License *(specify):*

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming.
Physical therapists must have a current license to practice physical therapy by the Wyoming Board of Physical Therapy per Wyoming Medicaid Rules, Chapter 45, Section 15.

Certificate *(specify):*

Other Standard *(specify):*

Home Health Agencies providing physical therapy services must assure physical therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Physical therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new home health agency providing physical therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency providing physical therapy services for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies providing physical therapy services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:
Speech Therapy
Service Definition *(Scope):*
Speech Therapy services consist of the full range of activities provided by a licensed speech therapist. Services include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy. Speech Therapy services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	individual certified to provide speech therapy services
Agency	Home Health Agency certified to provide speech therapy services
Agency	agency certified to provide speech therapy services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech Therapy

Provider Category:
Individual
Provider Type:
individual certified to provide speech therapy services
Provider Qualifications
License *(specify):*
An individual certified to provide speech therapy must have a current license to practice speech hearing and language services by the Wyoming Board of Speech Therapy per Wyoming Medicaid Rules, Chapter 45, Section 22.
Certificate *(specify):*

Other Standard *(specify):*
In addition to having a current license to practice speech therapy, speech therapists are required to complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Speech therapists must also complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Individuals certified to provide speech therapy services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide speech therapy services can be recertified for up to two years. Individuals certified to provide speech therapy services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification,and individuals certified to provide speech therapy services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor individuals certified to provide speech therapy services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech Therapy

Provider Category:
Agency

Provider Type:
Home Health Agency certified to provide speech therapy services

Provider Qualifications

License *(specify):*
Medicare certified or state licensed Home Health Agency fully licensed in Wyoming. Agencies providing speech therapy services are required to assure staff providing speech therapy services have a current license to practice speech hearing and language services by the Wyoming Board of Speech Therapy per Wyoming Medicaid Rules, Chapter 45, Section 22.

Certificate *(specify):*

Other Standard *(specify):*
Home Health Agencies providing speech therapy services must assure speech therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Speech therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new home health agency providing speech therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies providing speech therapy services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules

and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech Therapy

Provider Category:
Agency
Provider Type:
agency certified to provide speech therapy services
Provider Qualifications

License *(specify):*
Agencies providing speech therapy services are required to assure staff providing speech therapy services have a current license to practice speech hearing and language services by the Wyoming Board of Speech Therapy per Wyoming Medicaid Rules, Chapter 45, Section 22.

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing speech therapy services must assure speech therapists complete Central Abuse Registry Screenings and Criminal History Background checks, maintain current CPR and First Aid Certification, and have a current driver's license and automobile insurance if transporting participants. Speech therapists must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing speech therapy services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The Division has the authority to monitor agencies certified to provide speech therapy throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):
Agency with Choice

Service Definition *(Scope):*
The Agency with Choice - Financial Management Service (FMS) provider operates as co-employer with the waiver participant and/or their legal representative, who serve as the managing employer, for the purpose of ensuring that the necessary employer-related duties and tasks, including payroll are carried out as described below. Service only available to people self-directing at least one service under employer authority.

Participants or their legal representatives self-directing services under the Agency with Choice Financial Management Service do not have budgetary authority, including the option to purchase Individual Goods and Services.

Participants or their legal representatives who choose to self-direct services must choose either the Fiscal/Employer Agent Financial Management Service or the Agency with Choice Financial Management Service service. Requirements include:
1) Performing accurate and timely payroll services, providing workers compensation insurance and other benefits administration for workers, as applicable pursuant to federal and state rules and regulations.
2) Using generally accepted accounting practices for record keeping.
3) Serving as the co-employer for workers employed by the agency including those who are recruited, referred and managed by participants.
4) Processing criminal background checks and Central Registry checks on prospective employees as required or requested.
5) Assuring prospective employees meet the standards for the service being provided, including when applicable, maintaining current CPR and First Aid Certification, participant specific training, general training on recognizing abuse, neglect and exploitation, Division's Notification of Incident process, service documentation, HIPAA/Confidentiality, implementing objectives, and complaints/grievance procedures.
6) Receiving, responding to/resolve and track the receipt of calls and grievances from participants and their representatives and service providers, including the reporting of incidents as a mandatory reporter.
7) Providing services in accordance with the philosophy of self-direction.
8) Establishing a system for developing and maintaining Agency-with-Choice, participant, service worker, and vendor records and files (both current and archived) that is secure and HIPAA compliant.
9) Providing the co-employment services serving as the employer of record in which the participant, who is the managing employer has the rights and responsibilities to:
a. Recruit and refer prospective workers to the Agency-with-Choice for hire and assignment back to the participant.
b. Orient and train workers.
c. Determine workers' terms and conditions of work and work schedules.
d. Supervise workers' day-to-day activities.
e. Evaluate workers' performance.
f. Discharge workers as necessary from their work sites (homes).
g. Request that the Agency-with-Choice refer workers for consideration and assignment to the participant.
10) Developing and implementing a quality assurance program to ensure continuous quality improvement including measurements of participant satisfaction.
11) Developing an Agency with Choice FMS Policies and Procedure Manual that includes policies, procedures and internal controls for all Agency with Choice FMS tasks, including the requirements listed above. This Manual must be completed and reviewed by the DD Division before the agency can be certified in the Agency with Choice Service and must be updated as needed and at least every 12 months.
12) Obtaining a Certificate of Good Standing from the Wyoming Department of Employment, verifying provider is in compliance with the unemployment insurance and Workers Compensation requirements of Wyoming.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service only available to people self-directing at least one direct care service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-Accredited Agency certified by the DD Division
Agency	Agency certified by the DD Division

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Agency with Choice

Provider Category:
Agency
Provider Type:
CARF-Accredited Agency certified by the DD Division
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The DD Division requires agencies certified to provide Agency with Choice - Financial Management Services (FMS), who are also serving three or more participants in Residential Habilitation Services or Day Habilitation Services, to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 21 of the Wyoming Medicaid rules.
Other Standard *(specify):*
Providers must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, pursuant to Chapter 45, Section 21, all staff providing these Services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest. Other requirements include:
1) Performing accurate and timely payroll services, providing workers compensation insurance and other benefits administration for workers, as applicable pursuant to federal and state rules and regulations.
2) Using generally accepted accounting practices for record keeping.
3) Serving as the employer of record for workers employed by the agency including those who are recruited, referred and managed by participants.
4) Processing criminal background checks and Central Registry checks on prospective employees as required or requested.
5) Assuring prospective employees meet the standards for the service being provided, including when applicable, maintaining current CPR and First Aid Certification, participant specific training, general training on recognizing abuse, neglect and exploitation, DD Division’s Notification of Incident process, service documentation, HIPAA/Confidentiality, implementing objectives, and complaints/grievance procedures.
6) Receiving, responding to, resolve and track the receipt of calls and grievances from participants and their representatives and service providers, including the reporting of incidents as a mandatory reporter.

7) Providing services in accordance with the philosophy of self-direction.
8) Establishing a system for developing and maintaining Agency with Choice FMS status, participant, service worker, and vendor records and files (both current and archived) that is secure and HIPAA compliant.
9) Providing the co-employment services serving as the employer of record in which the participant, who is the managing employer has the rights and responsibilities to:
a. Recruit and refer prospective workers to the Agency with Choice FMS for hire and assignment back to the participant.
b. Orient and train workers.
c. Determine workers' terms and conditions of work and work schedules.
d. Supervise workers' day-to-day activities.
e. Evaluate workers' performance.
f. Discharge workers as necessary from their work sites (homes).
g. Request that the Agency with Choice FMS refer workers for consideration and assignment to the participant.
10) Developing and implementing a quality assurance program to ensure continuous quality improvement including measurements of participant satisfaction.
11) Developing an Agency with Choice FMS Policies and Procedure Manual that includes policies, procedures and internal controls for all Agency with Choice FMS tasks, including the requirements listed above. This manual must be completed and reviewed by the DD Division before the agency can be certified in the Agency with Choice Service and must be updated as needed and at least every 12 months.
12) Obtaining a Certificate of Good Standing from the Wyoming Department of Employment, verifying provider is in compliance with the unemployment insurance and Workers Compensation requirements of Wyoming.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new agency providing Agency with Choice - Financial Management Services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Agency with Choice

Provider Category:
Agency

Provider Type:
Agency certified by the DD Division

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Requirements include:
1) Performing accurate and timely payroll services, providing workers compensation insurance and other benefits administration for workers, as applicable pursuant to federal and state rules and regulations.
2) Using generally accepted accounting practices for record keeping.
3) Serving as the employer of record for workers employed by the agency including those who are recruited, referred and managed by participants.
4) Processing criminal background checks and Central Registry checks on prospective employees as required or requested.
5) Assuring prospective employees meet the standards for the service being provided, including when applicable, maintaining current CPR and First Aid Certification, participant specific training, general training on recognizing abuse, neglect and exploitation, DD Division's Notification of Incident process, service documentation, HIPAA/Confidentiality, implementing objectives, and complaints/grievance procedures.
6) Receiving, responding to, resolving and tracking the receipt of calls and grievances from participants and their representatives and service providers, including the reporting of incidents as a mandatory reporter.
7) Establishing a system for developing and maintaining Agency with Choice FMS status, participant, service worker, and vendor records and files (both current and archived) that is secure and HIPAA compliant.
8) Providing the co-employment services as outlined in the service definition, including giving the participant assistance to:
a. Recruit and refer prospective workers to the Agency with Choice FMS for hire and assignment back to the participant.
b. Orient and train workers.
c. Determine workers' terms and conditions of work and work schedules.
d. Supervise workers' day-to-day activities.
e. Evaluate workers' performance.
f. Discharge workers as necessary from their work sites (homes).
g. Request that the Agency with Choice FMS refer workers for consideration and assignment to the participant.
10) Developing and implementing a quality assurance program to ensure continuous quality improvement, including measurements of participant satisfaction.
11) Developing an Agency with Choice FMS Policies and Procedure Manual that includes policies, procedures and internal controls for all Agency with Choice FMS tasks, including the requirements listed above. This manual must be completed and reviewed by the DD Division before the agency can be certified in the Agency with Choice FMS Service and must be updated as needed and at least every 12 months.
12) Obtaining a Certificate of Good Standing from the Wyoming Department of Employment, verifying provider is in compliance with the unemployment insurance and Workers Compensation requirements of Wyoming.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new agency providing Agency with Choice - Financial Management Services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Independent Support Broker

Service Definition *(Scope):*

Independent Support Brokerage is a service that assists the participant (or the participant's legal representative, as appropriate) in arranging for, directing and managing services. The Support Broker serves as the agent of the participant or legal representative and is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. The Support Broker offers practical skills training to participants and their legal representatives to enable them to independently direct and manage waiver services. Support Brokers serve at the discretion of the participant and/or their legal representative.

Examples of practical skills training include providing information on recruiting and hiring direct care workers, managing workers and providing information on effective communication and problem-solving. The service includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the individual plan of care. This service does not duplicate other waiver services, including case management. Other functions include assisting the participant in:

1. Identifying immediate and long-term needs, preferences, goals and objectives of the participant for developing the individual plan of care.
2. Making decisions about the individual budget whether person is using the Fiscal/Employer Agent - Financial Management Service or Agency with Choice - Financial Management Service.
3. Developing options to meet the identified needs and access community services and supports specified in the individual plan of care whether person is using the Fiscal/Employer Agent - Financial Management Service or Agency with Choice - Financial Management Service.
4. Negotiating rates of payments and written agreements with service providers.
5. Selecting, hiring and training service providers, as applicable.
6. Developing and implementing risk management agreements and emergency back-up plans.
7. Conducting self-advocacy and assisting with employee grievances and complaints.
8. Assisting with filing grievances and complaints to outside entities, including the appropriate Financial Management Service provider and/or DD Division.
9. Providing information and practical skills training to the participant in the following areas:

a. Person-centered planning and its application.
b. The range and scope of individual choices and options.
c. The process for changing the individual plan of care and individual budget.
d. Recruitment and hiring of service workers.
e. Management of service workers, including effectively directing, communicating, and problem-solving.
f. Participant responsibilities in self-directed services, including the appeal process.
g. Recognition and reporting of abuse, neglect, and exploitation.

Support Brokers have responsibility for training all of the participant's employees on the Policy on Reportable Incidents and ensuring that all incidents meeting the criteria of the Division's Notification of Incident Process are reported. Support Brokers must review employee time sheets and monthly Fiscal Management Service (FMS) reports to ensure that the individualized budget is being spent in accordance with the approved Individual Plan and Budget, and coordinate follow-up on concerns with the participant's case manager.

Support Brokerage is a waiver service that is funded through the participant's individual budget.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service is a 15 minute unit. All paid Support Brokers shall be free of any conflict of interest including employment with a certified waiver provider or provision of any other Waiver service to the same participant. An Individual Support Broker hired by the participant shall only serve one participant, unless he/she is chosen to serve one additional sibling in the same household.

Support Brokerage is a required service for the first year a participant or representative self-directs services. After the first year, the participant or representative may opt out of Support Broker Services if he/she meets one of the criteria below and submits a formal request to opt out of Support Broker Services.

Criteria for Opting out of Support Broker Services includes the following, which is captured on a assessment tool completed by the case manager and approved by the DD Division:
1) Participants or their legal representatives who are self-directing through the Financial Management Service Agency with Choice who demonstrate the ability to choose workers, coordinate the hiring of workers through the Financial Management Service Agency with Choice provider, and coordinate the delivery of services with the Financial Management Service Agency with Choice provider.
2) Participants or their legal representatives self-directing less than $5,000 of support services who demonstrate the ability to hire, fire, train and schedule workers and review timesheets in a timely manner.
3) Participants or their legal representatives who have successfully self-directed services for one year with no concerns, including hiring, firing, training, scheduling workers and reviewing timesheets in a timely manner.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF-Accredited Agency certified to provide Support Brokerage Services
Individual	Individual certified by the DD Division
Agency	Agency certified to provide Support Brokerage Services
Individual	Individuals hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:
Agency
Provider Type:
CARF-Accredited Agency certified to provide Support Brokerage Services
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The DD Division requires agencies certified to provide Support Brokerage services who are also serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 21 of the Wyoming Medicaid rules.
Other Standard *(specify):*
Pursuant to Chapter 45, agencies certified to provide Support Brokerage Services must assure staff providing the service have one year of experience with a Bachelor's degree, Master's degree or Doctoral degree or two years (48 credit hours) of college and two years of experience working in the

field of developmental disabilities. Agencies must assure staff maintain current CPR and first aid certification, complete a criminal background screening including a DFS Central Registry Screening. Complete training on participant rights and rights restrictions, recognizing and reporting abuse, neglect, and exploitation, the Division's notification of incident process, billing and documentation, releases of information and confidentiality, grievance/complaint procedure, and recertification process. Agency staff providing Support Brokerage Services must attend a Division sponsored training on Support Brokerage and pass a competency based test on Support Brokerage prior to providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on case management services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency certified to provide Support Brokerage for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies certified to provide Support Brokerage services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the case manager is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:

Individual

Provider Type:

Individual certified by the DD Division

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Pursuant to Chapter 45, one year of experience with a Bachelor's degree, Master's degree or Doctoral degree or two years (48 credit hours) of college and two years of experience working in the field of developmental disabilities. Maintain current CPR and first aid certification, complete a criminal background screening including a DFS Central Registry Screening. Complete training on participant rights and rights restrictions, recognizing and reporting abuse, neglect, and exploitation, the Division's notification of incident process, billing and documentation, releases of information and confidentiality, grievance/complaint procedure, and recertification process. Attend a Division sponsored training on Support Brokerage and pass a competency based test on Support Brokerage

prior to providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Prior to being certified as a Support Broker provider, applicants shall show evidence of a successful Central Abuse Registry Screening , a successful Criminal History Background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current CPI or MANDT certification (if applicable) prior to being employed and providing waiver services.

Upon certification, support broker providers are required to maintain current CPR and First Aid certification, CPI or MANDT (if applicable), and current driver's license and vehicle insurance (if transporting participants). If the Division receives notification that the provider has been charged with an offense that would list them on the Central Registry or has been charged with an offense listed in Chapter 45, section 25 of Medicaid Rules, then the provider shall immediately complete and show evidence of a successful Central Registry check or a Criminal History Background check prior to being allowed to continue providing waiver services.

The DD Division initially certifies a new individual providing Support Brokerage Services for one year and the individual is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an individual for up to two years. Individuals who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.
The DD Division has the authority to monitor individuals throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the individual is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:
Agency

Provider Type:
Agency certified to provide Support Brokerage Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Pursuant to Chapter 45, agencies certified to provide Support Brokerage Services must assure staff providing the service have one year of experience with a Bachelor's degree, Master's degree or Doctoral degree or two years (48 credit hours) of college and two years of experience working in the field of developmental disabilities. Agencies must assure staff maintain current CPR and first aid certification, complete a criminal background screening including a DFS Central Registry Screening. Complete training on participant rights and rights restrictions, recognizing and reporting abuse, neglect, and exploitation, the Division's notification of incident process, billing and documentation, releases of information and confidentiality, grievance/complaint procedure, and recertification process. Agency staff providing Support Brokerage Services must attend a Division sponsored training on Support Brokerage and pass a competency based test on Support Brokerage

prior to providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new agency providing Support Brokerage Services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.
The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:
Individual

Provider Type:
Individuals hired by the participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The Fiscal Employer Agent FMS verifies the individual chosen by the participant or their legal representative:
• Is at least 21 yrs of age
• Has a High School Diploma and three years experience in the field of developmental disabilities
• Has completed required DD Division training on Support Brokerage and pass a competency based test before being providing Support Brokerage services.
• Has completed a successful criminal background check
• Has completed a successful Central Registry check
• Has the ability to communicate effectively with the individual/family
• Has the ability to complete record keeping as required by the employer
• Has current CPR and First Aid Certification
• Has a current driver's license and automobile insurance if transporting the participant
• Demonstrates competence in knowledge of the following DD Division policies and procedures: recognizing abuse/neglect; incident reporting; participant rights and confidentiality;
• Demonstrates competence/knowledge in participants needs outlined in the individual plan of care.
* Attend a Division-sponsored training on Support Brokerage and pass a competency based test on Support Brokerage prior to providing the service.

Individuals chosen by participants or their legal representatives to provide Support Broker Services can only provide Support Brokerage Services to the participant who chose the individual. The DD Division has an audit process in place in conjunction with the Fiscal/Employer Agent FMS and Agency with Choice FMS to prevent an individual from providing Support Broker Services to more than one participant. If an individual is hired to provide Support Brokerage Services to one participant through the Fiscal Employer Agent FMS and the individual wants to serve more than the

one participant, the individual must meet the qualifications for Support Brokerage and become a Medicaid certified Support Broker through the DD Division.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal/Employer Agent FMS or Agency with Choice FMS

Frequency of Verification:

Prior to being certified as a support broker provider, applicants shall show evidence of a successful Central Abuse Registry Screening, a successful Criminal History Background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current CPI or MANDT certification (if applicable) prior to being employed and providing waiver services.

Upon certification, support broker providers are required to maintain current CPR and First Aid certification, CPI or MANDT (if applicable), and current driver's license and vehicle insurance (if transporting participants). If the Division receives notification that the provider has been charged with an offense that would list them on the Central Registry or has been charged with an offense listed in Chapter 45, Section 25 of Medicaid Rules, then the provider shall immediately complete and show evidence of a successful Central Registry check or a Criminal History Background check prior to being allowed to continue providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. In addition, any documentation that has an expiration date such as CPR and First Aid are entered into their database as to the date of when it expires.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent - FMS database is updated and the FMS allows the employee to start work. Fiscal Employer Agent - FMS also does quarterly reviews on a random sample of files to ensure that documents are in and marked correctly. The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to the case manager, which includes a status of upcoming training expirations of providers.

With assistance from the case manager, the participant will take on the responsibility and provide additional oversight in ensuring that all employees are current on all required certifications that have an expiration date such as CPR, First Aid, and Medication Assistance. After the first year of self-direction, before the participant will be allowed to "opt out" of having a support broker, the Division will ensure that the participant and/or their legal representative understands their oversight responsibility in ensuring all providers are current in required certifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Cognitive Retraining

Service Definition *(Scope):*

Training provided to the person served or family members that will assist the compensation or restoring cognitive function (e.g. ability/skills for learning, analysis, memory, attention, concentration, orientation, and information processing) in accordance with the Plan of Care (POC).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	agency certified to provide cognitive retraining services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Retraining

Provider Category:
Agency
Provider Type:
agency certified to provide cognitive retraining services
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Agencies certified to provide cognitive retraining services are required to verify agency staff providing the services are certified in Cognitive Retraining from an accredited institution of higher learning, or be a certified Brain Injury Specialist through the Brain Injury Association of America, or be a licensed professional with one year of acquired brain injury training or Bachelors degree in related field and three years experience in acquired brain injuries.
Other Standard *(specify):*
Agency staff providing cognitive retraining services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Agency staff must also complete and document applicable participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing cognitive retraining services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The Division has the authority to monitor agencies certified to provide cognitive retraining services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion Services

Service Definition *(Scope):*

Companion services include non-medical care, supervision, socialization and assisting an adult waiver participant in maintaining safety in the home and community and enhancing independence. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. Companion services include informal training goals in areas specified in the individual plan of care. The provision of companion services does not entail hands-on nursing care, but does include personal care assistance with activities of daily living as needed during the provision of services. Transportation is included in the reimbursement rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is a 15 minute unit and is available as a 1:1 service or a group rate. With the group rate, providers can provide companion services for up to three participants at the same time.

Personal Care is included in this service and cannot be used in conjunction with this service.

Companion services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency certified to provide companion services
Individual	Individual hired by the participant
Agency	CARF-accredited agency certified by DD Division

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:
Agency
Provider Type:
Agency certified to provide companion services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing Companion Services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 22, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing Companion Services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. In addition, agencies must meet the requirements pursuant to Chapter 45 of Wyoming Medicaid Rules. Agency direct care staff must complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest. Agencies, who are not serving people in a home or facility they own or lease, must have policies and procedures in place addressing, as applicable, emergency situations and drills, weapons, smoking, pets, incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing Companion Services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies, who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation, receive a two year recertification.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:
Individual
Provider Type:
Individual hired by the participant
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The following is verified by the Fiscal/Employer Agent - Financial Management Service (FMS) or Agency with Choice FMS:
• individual is at least 18 yrs of age
• successful criminal background check
• successful central registry check
• have ability to communicate effectively with the individual/family
• have ability to complete record keeping as required by the employer
* have current CPR and First Aid certification
* If transporting, documentation of current auto insurance and driver's license.

Prior to working alone with the individual:
• demonstrate competence in knowledge of the following DD Division policies and procedures: recognizing abuse/neglect; incident reporting; participant rights and confidentiality; emergency drills/situations,
• demonstrate competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal/Employer Agent FMS or Agency with Choice FMS

Frequency of Verification:
Companion service providers employed under the Financial Management Service are required to show evidence of a successful Central Abuse Registry Screening, a successful Criminal History Background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current CPI or MANDT certification (if applicable) prior to being employed and providing waiver services.

Upon employment, companion service providers are required to maintain current CPR and First Aid certification, CPI or MANDT (if applicable), and current driver's license and vehicle insurance (if transporting participants). If the Division receives notification that the provider has been charged with an offense that would list them on the Central Registry or has been charged with an offense listed in Chapter 45, section 25 of Medicaid Rules, then the provider shall immediately complete and show evidence of a successful Central Registry check or a Criminal History Background check prior to being allowed to continue being employed and providing waiver services.

The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. In addition, any documentation that has an expiration date such as CPR and First Aid are entered into their database as to the date of when it expires.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent - FMS database is updated and the FMS allows the employee to start work. Fiscal Employer Agent - FMS also does quarterly reviews on a random sample of files to ensure that documents are in and marked correctly. The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers.

With assistance from the support broker, the participant will take on the responsibility and provide additional oversight in ensuring that all employees are current on all required certifications that have an expiration date such as CPR, First Aid, and Medication Assistance. After the first year of self-direction, before the participant will be allowed to "opt out" of having a support broker, the Division will ensure that the participant and/or their legal representative understands their oversight responsibility in ensuring all providers are current in required certifications.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Services

Provider Category:
Agency
Provider Type:
CARF-accredited agency certified by DD Division
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Agencies providing companion services that are also providing residential and/or day habilitation services to three or more participants are required to obtain and maintain CARF accreditation per Wyoming Medicaid Rules, Chapter 45, Section 21.
Other Standard *(specify):*
CARF-accredited agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, pursuant to Chapter 45, agencies must complete a Central Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants for all staff working directly with participants. Agencies must meet the requirements pursuant to Chapter 45 of Wyoming Medicaid Rules. The Agency must also complete and document participant specific training of all staff before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies serving people in a facility they own or lease must have policies and procedures in place addressing emergency situations and drills, external and internal inspections, weapons, smoking, pets, incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accrediddtation report and corresponding quality improvement plans.

Agencies are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, agencies can be recertified for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Dietician Services

Service Definition *(Scope):*

Dietician Services provided by a registered dietician include menu planning, consultation with and training for caregivers, and education for the individual served. The service does not include the cost of meals.

Dietician Services are not available under the State Plan. Without this service certain individuals would receive inadequate nourishment and would require institutionalization.

The Dietician services are those services designated in the participant's Individual Plan of Care (IPC). The clientele served by this service show a pattern of chronic and unusual need requiring Dietician Services, which are not provided by the State Plan. Chronic needs encompass conditions such as severe obesity, poor food choices that compromise health, special diets approved by a physician for specific diagnoses or severe allergies.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual certified to provide Dietician Services
Agency	Agency certified to provide Dietician Services
Agency	Home Health Agency certified to provide dietician services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dietician Services

Provider Category:

Individual

Provider Type:

Individual certified to provide Dietician Services

Provider Qualifications

License *(specify):*

An individual certified to provide Dietician Services must have a current license to practice as a Dietician by the Commission on Dietetic Registration.

Certificate *(specify):*

Other Standard *(specify):*
In addition to having a current license to practice as a dietician, dieticians are required to complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR Certification and have a current driver's license and automobile insurance if transporting participants. Dieticians must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Individuals certified to provide Dietician Services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide Dietician Services can be recertified for up to two years. Individuals certified to provide Dietician Services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide Dietician Services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor providers throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dietician Services

Provider Category:
Agency

Provider Type:
Agency certified to provide Dietician Services

Provider Qualifications

License *(specify):*
Agencies certified to provide dietician services are required to verify staff providing dietician services have a current license to practice as a dietician by the Commission on Dietetic Registration.

Certificate *(specify):*

Other Standard *(specify):*
Agencies must ensure all staff providing dietician services to participants complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Agency staff providing dietician services must also complete and document applicable participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new agency providing dietician services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year

certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The Division has the authority to monitor individuals certified to provide dietician services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dietician Services

Provider Category:

Agency

Provider Type:

Home Health Agency certified to provide dietician services

Provider Qualifications

License *(specify):*

Medicare certified or state licensed Home Health Agency fully licensed in Wyoming. Agencies certified to provide dietician services are required to verify staff providing dietician services have a current license to practice as a dietician by the Commission on Dietetic Registration.

Certificate *(specify):*

Other Standard *(specify):*

Home Health Agencies must ensure all staff providing dietician services to participants complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Agency staff providing dietician services must also complete and document applicable participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The DD Division initially certifies a new home health agency providing dietician services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify a home health agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor home health agencies providing dietician services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

Service Definition *(Scope):*

A physical adaptation to the primary residence of a waiver participant that is functionally necessary, and either 1) contributes to a participant's ability to remain in or return to his/her home, and/or 2) is necessary to ensure the health, welfare and safety of the participant.

Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electrical and plumbing adaptations that accommodate the medical equipment necessary for the welfare of the participant.

Environmental modification requests shall support the needs identified within the plan of care and meet criteria as defined in Wyoming Medicaid rules, Chapter 44, rules for Environmental Modifications and Specialized Equipment, Section 6 and 7. The DD Division shall determine if the environmental modification request is necessary for the participant before prior authorizing the service on the plan of care.

Exclusions: An environmental modification, which adds to the total square footage of the home, is excluded from this benefit, except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). An accessibility modification to adapt living arrangements in a home, which is owned or leased by providers of waiver services, is not eligible for reimbursement. Adaptations or improvements to the home that are of general utility, primarily for the convenience of persons other than the participant, or not of direct medical or remedial benefit to the participant are excluded from this service. Scope and Limitations of this service are found in Wyoming Medicaid rules, Chapter 44, Section 6.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	individual certified to provide environmental modification services
Agency	agency certified to provide environmental modification services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

individual certified to provide environmental modification services

Provider Qualifications

License *(specify):*

Individuals certified to provide environmental modification services must have the applicable building, electrical, plumbing contractor's license as required by local or state regulations.

Certificate *(specify):*

Other Standard *(specify):*

In addition to having the applicable building, electrical, plumbing contractor's license as required by local or state regulations, individuals certified to provide environmental modification services must also complete training on incident reporting, recertification, and HIPAA & Confidentiality.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide environmental modification services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide environmental modification services can be recertified for up to two years. Individual certified to provide environmental modification services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide environmental modification services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The DD Division has the authority to monitor individuals certified to provide environmental modification services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

agency certified to provide environmental modification services

Provider Qualifications

License *(specify):*

Agencies certified to provide environmental modification services are required to assure they have the applicable building, electrical, plumbing contractor's license as required by local or state regulations.

Certificate *(specify):*

Other Standard *(specify):*

Agencies must assure staff providing environmental modification services complete and document general trainings on recognizing abuse and neglect, incident reporting, and HIPAA & Confidentiality requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:
The DD Division initially certifies a new agency providing environmental modification services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The Division has the authority to monitor providers throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
In Home Support - phased out Year 1

Service Definition *(Scope):*
This service will be phased out in Year 1 of the waiver renewal.

The provision of habilitation services to individuals who reside with their family or independently. In-home support services includes conducting a designed program to allow the individual with acquired brain injury to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in the community. Individuals are trained in techniques to address functional deficits in self-help, daily living skills, mobility, learning, communication, self-sufficiency, survival skills, reduction of maladaptive behaviors, community access and other necessary skills.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF Accredited agency certified to provide in home support services
Agency	Agency certified to provide in home support services
Individual	individual certified to provide in home support services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In Home Support - phased out Year 1

Provider Category:

Agency

Provider Type:

CARF Accredited agency certified to provide in home support services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The DD Division requires providers certified to provide in-home support services who are serving three or more participants in Residential Habilitation Services or Day Habilitation Services to maintain accreditation by the Commission on Accreditation of Rehabilitative Facilities (CARF) per Chapter 45, Section 23 of the Wyoming Medicaid rules.

Other Standard *(specify):*

Agencies must meet all applicable CARF Standards and maintain CARF accreditation. These standards cover leadership, strategic planning, health and safety, human resources, rights of participants, quality improvement within the agency, employment services, community services, and individualized services and supports. In addition, all staff providing in-home support services to participants must complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Provider staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition to the policies and procedures required by the CARF standards, providers must also have policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

The Commission on Accreditation of Rehabilitative Facilities (CARF) accredits providers for either a three year period or a one year period. The accreditation process includes an on-site survey and resulting report that summarizes the provider's compliance with CARF standards, including standards on employment services. Providers are required to submit quality improvement plans to CARF for any standards they are not in compliance with. The DD Division receives copies of the accreditation report and corresponding quality improvement plans.

In addition to the CARF accreditation, the DD Division initially certifies a new agency providing in-home support services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a two year recertification.

The DD Division has the authority to monitor agencies services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In Home Support - phased out Year 1

Provider Category:
Agency
Provider Type:
Agency certified to provide in home support services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing in home support services must meet the requirements in Wyoming Medicaid rules, Chapter 45, Section 24, including completing a Central Abuse Registry Screening and a Criminal History Background check on all staff providing in home support services upon hire, maintaining current CPR and First Aid Certification for all direct care staff, and assuring staff transporting participants have a current driver's license and automobile insurance. Agency direct care staff must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. Agencies must post emergency plans, complete emergency drills, complete internal and external inspections, adhere to documentation standards, and develop and implement policies and procedures for incident reporting, restraint usage, and conflicts of interest.

Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing in home support services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The DD Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the agency is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In Home Support - phased out Year 1

Provider Category:
Individual
Provider Type:
individual certified to provide in home support services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individuals certified to provide in home support services must be 18 years of age or older, complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR and First Aid Certification and have a current driver's license and automobile insurance if transporting participants. Individuals certified to provide in home support services must also complete and document participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, implementing objectives, and HIPAA & Confidentiality requirements. In addition, individuals certified to provide in home support services serving people in a facility they own or lease must also have policies and procedures in place addressing emergency situations and drills, external and internal inspections, weapons, smoking , pets, incident reporting, restraint usage, and conflicts of interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older living in the home. Individuals certified to provide in home support services who are not serving people in a home or facility they own or lease must have policies and procedures in place addressing, as applicable, emergency situations and drills, weapons, smoking , pets, incident reporting, restraint usage, and conflicts of interest. They must also complete Central Abuse Registry screenings and Criminal History Background checks on all people 18 years of age or older participating in the delivery of services.

If a person living in the home does not meet the background check requirements the individual certified to provide in home support services is not be approved to provide services in that home. The individual certified to provide in home support services is also required to sign a "Not In My Home" form stating that under no circumstances will services be provided in their home or they may be decertified as a waiver provider.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Individuals certified to provide in home support services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide in home support services can be recertified for up to two years. Individuals certified to provide in home support services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide in home support services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor individuals certified to provide in home support services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Individually-Directed Goods and Services
Service Definition *(Scope):*
Goods and services are services, equipment, and supplies that provide direct benefit to the participant and support specific outcomes in the individual plan of care. The service, equipment or supply must:
1. Reduce the reliance of the participant on other paid supports, or
2. Be directly related to health or safety of the participant in the home or community, or
3. Be habilitative and contribute to a therapeutic objective, or
4. Increase the participant's ability to be integrated into the community, or
5. Provide resources to expand self-advocacy skills and knowledge.
Goods and Services may include:
• Specialized equipment
• Devices, aids, controls, supplies, or household appliances which enable individuals to increase the ability to perform activities of daily living or to perceive, control, or communicate with the environment and/or community in which s/he lives. Service includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Service includes vehicle modifications but does not include items of direct medical or remedial benefit to the individual. All items must meet applicable standards of manufacture, design, and installation.
• • Transportation provided by family members (excluding parents, step-parents, guardians, or spouses per Wyoming State Statute), friends, and other licensed drivers for using non-agency vehicles to transport the person to services and activities specified in the person's individual plan of care unless the service includes transportation. The unit of service is one mile. The rate may not exceed the current state rate for mileage reimbursement and cannot include medical transportation covered by the Medicaid State Plan.
• Home modifications - Physical adaptations which are necessary to ensure the health, welfare, and safety of the individual in the home, enhance the individual's level of independence, or which enable the individual to function with greater independence in the home.
• Camps - May cover cost of the participant attending a camp, and in some cases, an attendent to accompany the person to a camp that he/she could not attend alone and additional staffing was not available at the camp to ensure the person's health and safety.
• Consultation, evaluation and training, and/or a written document that evaluates and identifies the participant's strengths, needs, current availability and potential capacity of natural supports, and the need for service and financial resources, if appropriate. As appropriate for the participant, a consultation shall include participant preferences, health status, medications, conditions and treatments, functional performance, including Activities of Daily Living (ADLs), level of assistance needed, and assistive devices used and/or needed. Behavior and emotional factors, including pertinent history, coping mechanisms, and stressors. Cognitive functioning, including memory, attention, judgment, and general cognitive measures. Environmental factors, including architectural, transportation, other barriers. Social supports and networks, including natural supports. Financial factors, including guardianship or conservatorships, or entitlements that influence the array of supports and services that are needed.

Consultations and evaluations may be warranted based upon a specific disability, diagnosis, behavior concern, or medical condition relating to the disability. Family members and the person's environment may be involved in the consultation and training, which will help the person increase their health and safety, minimize the use of paid supports, and reduce the likelihood of institutionalization. This consultation and evaluation shall be used by the family and participant's team to better provide both paid and unpaid supports for the participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Individually Directed Goods and Services have a $2,000 annual limit. All goods and services must be prior authorized by the DD Division and cannot be available through Specialized Equipment or Environmental Modifications on the waiver as specified in Chapter 44 of the Medicaid Rules. The DD Division may approve requests above the limit if the request meets the specified criteria. Criteria for approving requests above the limit shall include goods or service needs that are due to:
• Unmet needs because of aging out of school
• Documented unavailability of vocational rehabilitation services
• Increasing health concerns that require more services
• Increasing behavioral concerns that require more intervention
• Health needs of unpaid caregivers who cannot continue the historical level of support.
This service is only available for individuals who self-direct their own supports. This service may not duplicate any Medicaid State Plan service.

Limitations:

Modifications to a residence are not approved when the cost of such modifications exceeds the value of the residence before the modification. Covered modifications of rented or leased homes shall be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible. Does not include adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit, nor adaptations that add to the total square footage of the home.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Commercial/Retail Businesses
Individual	Individuals hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individually-Directed Goods and Services

Provider Category:
Agency
Provider Type:
Commercial/Retail Businesses
Provider Qualifications
License *(specify):*
Applicable state/local business license
Certificate *(specify):*

Other Standard *(specify):*
Meets applicable state and local requirements for type of item that the vendor is providing.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Employer Agent-Financial Management Service
Frequency of Verification:
Prior to employment or prior to processing invoice - Fiscal Employer Agent - Financial Management Service shall verify the provider qualifications for the good or service being purchased

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individually-Directed Goods and Services

Provider Category:
Individual

Provider Type:
Individuals hired by the participant
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
When direct services are provided by individual the following is verified by the Fiscal/Employer Agent - Financial Management Service: • Individual is at least 18 yrs of age • Successful criminal background check • Successful central registry check • Has ability to communicate effectively with the individual/family • Has ability to complete record keeping as required by the employer • Has CPR and First Aid Certification • If transporting documentation of a current driver's license and auto insurance • If providing a service requiring licensing, certification or other educational requirements, verification that requirements are met Prior to working alone with the individual: • Demonstrates competence in knowledge of the following DD Division policies and procedures: recognizing abuse/neglect; incident reporting; participant rights and confidentiality; emergency drills/situations, • Demonstrates competence/knowledge in participants needs outlined in the individual plan of care

Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal/Employer Agent - Financial Management Service
Frequency of Verification:
Goods and Services providers, who are providing a direct care service, employed under the Financial Management Service are required to show evidence of a successful Central Abuse Registry Screening, a successful Criminal History Background, current CPR and First Aid certification, current driver's license and vehicle insurance (if transporting participants), and current CPI or MANDT certification (if applicable) prior to being employed and providing waiver services.

Upon employment, goods and services providers are required to maintain current CPR and First Aid certification, CPI or MANDT (if applicable), and current driver's license and vehicle insurance (if transporting participants). If the DD Division receives notification that the provider has been charged with an offense that would list them on the Central Registry or has been charged with an offense listed in Chapter 45, section 25 of Medicaid Rules, then the provider shall immediately complete and show evidence of a successful Central Registry check or a Criminal History Background check prior to being allowed to continue being employed and providing waiver services.
The Fiscal Employer Agent - FMS inputs all employee information into a database, which shows each item that an employee has completed in order to qualify to provide services to a participant. In addition, any documentation that has an expiration date such as CPR and First Aid are entered into their database as to the date of when it expires.

Once an employee shows that all documentation is submitted, the Fiscal Employer Agent - FMS database is updated and the FMS allows the employee to start work. Fiscal Employer Agent - FMS also does quarterly reviews on a random sample of files to ensure that documents are in and marked correctly. The Agent provides a weekly status report to support brokers regarding provider certifications, paperwork, status of trainings, and whether or not the provider has met all requirements to work for a participant. The Agent also provides a monthly report to support brokers, which includes a status of upcoming training expirations of providers.

With assistance from the support broker, the participant will take on the responsibility and provide additional oversight in ensuring that all employees are current on all required certifications that have an expiration date such as CPR, First Aid, and Medication Assistance. After the first year of self-direction, before the participant will be allowed to "opt out" of having a support broker, the Division will ensure that the participant and/or their legal representative understands their oversight responsibility in ensuring all providers are current in required certifications.

Appendix C: Participant Services

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Skilled Nursing

Service Definition *(Scope):*

Services listed in the plan of care that are within the scope of the State's Nurse Practice Act. Skilled nursing services under the waiver differ in provider type (including provider training and qualifications) from skilled nursing services in the Medicaid State plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Skilled nursing on the ABI Waiver may be provided by provider agencies and independent nurses as long as they meet the provider qualifications. The Wyoming Medicaid State Plan requires that skilled nursing services be provided by home health agencies that provide a minimum of two medically necessary services.

Skilled nursing is not covered as a stand-alone service through the state plan. It can be provided on an intermittent basis through home health only. A home health provider typically provides services from 8 am to 5 pm. Being a rural state, many Wyoming communities do not have home health providers to serve their community. Those that do often do not have enough employees to meet the extensive needs of some waiver participants. Waiver participants who need skilled nursing services must utilize providers that can provide the type, amount and flexible hours of services deemed most appropriate for the participant. The waiver service allows the team to find and utilize providers who can best meet the participant's needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	individual certified to provide skilled nursing services
Agency	agency certified to provide skilled nursing services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

individual certified to provide skilled nursing services

Provider Qualifications

License *(specify):*

Individuals providing skilled nursing services must have a current license to practice nursing by the

Wyoming State Board of Nursing per Wyoming Medicaid Rules, Chapter 45, Section 19. Individuals providing skilled nursing services must be a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

Certificate *(specify):*

Other Standard *(specify):*

In addition to having a current license to practice nursing, skilled nurses are required to complete a Central Abuse Registry Screening, a Criminal History Background check, maintain current CPR Certification and have a current driver's license and automobile insurance if transporting participants. Skilled nurses must also complete and document the appropriate participant specific training before serving a participant, and complete and document general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, provider recertification requirements, rights and rights restrictions, and HIPAA & Confidentiality requirements. Skilled nurses can only provide skilled nursing services as prescribed by a medical professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

Developmental Disabilities Division

Frequency of Verification:

Individuals certified to provide skilled nursing services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide skilled nursing services can be recertified for up to two years. Individuals certified to provide skilled nursing services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide skilled nursing services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor individuals certified to provide skilled nursing services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

agency certified to provide skilled nursing services

Provider Qualifications

License *(specify):*

Agencies certified to provide skilled nursing services are required to assure individuals providing skilled nursing services have a current license to practice nursing by the Wyoming State Board of Nursing per Wyoming Medicaid Rules, Chapter 45, Section 19.

Certificate *(specify):*

Other Standard *(specify):*

Agencies certified to provide skilled nursing services must assure nurses providing skilled nursing services have completed and documented applicable participant specific training before serving a participant, and completed and documented general trainings on recognizing abuse and neglect, incident reporting, complaint process requirements, documentation standards, rights and rights restrictions, and HIPAA & Confidentiality requirements. Agencies must also assure skilled nursing services are prescribed by a medical professional.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
The DD Division initially certifies a new agency providing skilled nursing services for one year and the agency is required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification.

The Division has the authority to monitor individuals certified to provide skilled nursing services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Equipment
Service Definition *(Scope):*
Specialized equipment includes: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live (c) items necessary for life support or to address physical conditions along with ancillary supplied and equipment necessary to the proper functioning of such items.(d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limitations of this service are found in Medicaid Rule Chapter 44.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	individual certified to provide specialized equipment services

Agency	agency certified to provide specialized equipment services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment

Provider Category:
Individual
Provider Type:
individual certified to provide specialized equipment services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
individuals certified to provide specialized equipment services must be 18 years of age or older and provide specialized equipment services pursuant to Wyoming Medicaid Rules, Chapter 44.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Division
Frequency of Verification:
Individuals certified to provide specialized equipment services are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, individuals certified to provide specialized equipment services can be recertified for up to two years. Individuals certified to provide specialized equipment services who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and individuals certified to provide specialized equipment services who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor individuals certified to provide specialized equipment services throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication of non-compliance with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment

Provider Category:
Agency
Provider Type:
agency certified to provide specialized equipment services
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies certified to provide specialized equipment services are required to assure staff providing this service are 18 years of age or older and are adhering to Wyoming Medicaid rules, Chapter 44.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Division

Frequency of Verification:
Providers are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, providers can be recertified for up to two years. Providers who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive up to a one year recertification, and providers who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation receive a two year recertification. The Division has the authority to monitor providers throughout their recertification period through the complaint process, incident reporting process, or internal referral process if there is indication the provider is not complying with the rules and regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Unpaid Caregiver Training and Education

Service Definition *(Scope):*
This service enables family members and other unpaid caregivers to gain the knowledge and skills needed to participate more fully in various aspects of caring and advocating for a participant with a disability in their homes, schools and communities. This service includes learning the various techniques and intervention strategies necessary to help a participant to progress, instruction on equipment use as specified in the individual plan of care, and updates as necessary to safely maintain the individual at home. Education includes reimbursement of registration fees for unpaid caregivers to attend seminars and similar opportunities for knowledge dissemination when such opportunities are approved as appropriate. Education must be included in the participant plan of care. Only training and education that is determined to be for the purpose of improving the care of the participant and/or otherwise contributing to the greater welfare of the participant will be approved. Unpaid caregivers are the persons who live with or provide care to a participant on the waiver and may include a parent, spouse, children, relatives, foster family, in-laws, neighbors or other people providing natural supports. This does not include individuals who are employed to care for the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
$2,000 annual limit. The limit provides adequate funding for attending a conference, including conference fees and depending on the location, provides adequate funding for targeted training by professionals. Service cannot cover the costs of travel, meals and overnight lodging to attend a training event or conference. The DD Division shall review any request above the specified limit and may approve the request if it is within the person's individualized budget amount and based upon the health and safety needs of the participant. Criteria for approval above this limit may include that the unpaid caregiver training must address critical health or welfare needs, the unpaid caregiver training is a one-time training to assure unpaid caregivers can fulfill their role successfully reducing the need for waiver services, or other extenuating circumstances. All services must be prior authorized by the Developmental Disabilities Division.

Service Delivery Method *(check each that applies)*:

☑ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual hired by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Unpaid Caregiver Training and Education

Provider Category:
Individual

Provider Type:
Individual hired by the participant

Provider Qualifications

License *(specify):*
Individual maintains current license or certificate if required for training

Certificate *(specify):*
Individual maintains current license or certificate if required for training

Other Standard *(specify):*
The specific training must be prior authorized by the DD Division.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal/Employer Agent FMS or Agency with Choice FMS

Frequency of Verification:
Before training or education is provided

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case managers are not employed by the state. They are either employed by a Medicaid Waiver provider organization certified to provide case management services, or independently certified as a Medicaid Waiver provider to provide case management services. Case managers are responsible for developing and submitting a service plan for a participant once a year. The case manager must coordinate at least two team meetings a year related to a participant's service plan, once to develop the annual plan of care, and a six-month plan review meeting. Case managers must make a monthly home visit to the participant's home.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The DD Division manages the provider background check process and requires all ABI Waiver providers, ABI Waiver provider staff, and direct service workers chosen by self-directing participants to complete a Federal Bureau of Investigation (FBI) fingerprint background check and State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check per Wyoming Medicaid rules, Chapter 45. The only exceptions are ABI Waiver providers certified to provide environmental modifications, specialized equipment, or services funded through Individual Goods and Services that are not direct services. These service providers or staff are not required to complete a background check since they are not providing direct services.

Any time a provider chooses to add a direct service to their provider certification, the DD Division requires the provider to complete a background screening before the provider is approved to provide the service. Anytime a participant or their representative self-directing a service chooses to hire a new worker, the Financial Management Service must assure the background check process is completed before the worker can receive reimbursement for working for the participant.
The background check must verify the provider, provider staff, or worker employed by a self-directing participant has not been convicted of an Offense Against the Person or an Offense Against Morals, Decency and Family, including:
Homicide (W.S. § 6-2-101 et seq.)
Kidnapping (W.S. § 6-2-201 et seq.)
Sexual assault (W.S. § 6-2-301 et seq.)
Robbery and blackmail (W.S. § 6-2-401 et seq.),
Assault and battery (W.S. § 6-2-501 et seq.),
Bigamy (W.S. § 6-4-401)
Incest (W.S. § 6-4-402)
Abandoning or endangering children (W.S. § 6-4-403)
Violation of order of protection (W.S. § 6-4-404), and
Endangering children; controlled substances (W.S. § 6-4-405), or
Similar laws of any other state or the United States relating to these crimes.

The DD Division requires provider applicants to complete a background check before they are certified to provide services. To assure the background check is completed the DD Division submits the background check paperwork to the Wyoming Division of Criminal Investigation and receives the results of the background check verifying the provider applicant has no convictions which disqualify him/her to provide waiver services. The results are maintained in the provider file. Provider agency staff are required to submit to the background check upon hire and to maintain verification of the results of the background check in the individual staff's personnel file. The DD Division completes a staff file review of provider agencies during the provider recertification process to assure background checks have been completed and to verify that staff meet the background check

requirements to provide waiver services. The Division also oversees the Financial Management Service provider to assure background checks are completed before workers hired by the participant begin working with the participant.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

○ **No. The State does not conduct abuse registry screening.**

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Wyoming Department of Family Services maintains the Central Registry of child and disabled adult protection cases, as authorized in Wyoming State Statute W.S. §7-19-201. All ABI Waiver providers, provider staff, and direct care workers chosen by self-directing participants are required to complete a Central Registry Screening per Wyoming Medicaid rules, Chapter 45. The only exceptions are ABI Waiver providers certified to provide environmental modifications, specialized equipment, or services funded through Individual Goods and Services that are not direct services. These providers or workers are not required to complete a background check since they are not providing direct services. Any time a provider chooses to add a direct service to their provider certification, the DD Division requires the provider to complete a Central Registry screening that verifies the person does not appear on a substantiated Wyoming Department of Family Services Central Registry, per Wyoming Medicaid rules, Chapter 45, Provider Certification and Sanctions. Anytime a participant or their representative self-directing a service chooses to hire a new worker, the Financial Management Service must assure the background check process is completed before the worker can receive reimbursement for working for the participant.

The DD Division requires ABI Waiver provider applicants to complete the Central Registry Screening before they are certified to provide services. To assure the Central Registry Screening is completed the DD Division submits the screening paperwork to the Wyoming Department of Family Services and receives the results of the screenings, which are maintained in the provider file. ABI Waiver Providers employing staff are required to complete the Central Registry Screening for all staff providing direct services at the time of hire. The provider submits the screening paperwork to the Wyoming Department of Family Services and receives the results of the screenings, which are maintained in the individual staff's personnel file. The DD Division completes a staff file review of provider agencies during the provider recertification process to assure the Central Registry Screenings have been completed and to verify that staff meet the screening requirements to provide waiver services. ABI Waiver providers certified to provide environmental modifications,
specialized equipment, or services funded through Individual Goods and Services that are not direct services. These providers or workers are not required to complete a background check since they are not providing direct services. Any time a provider chooses to add a direct service to their provider certification, the DD Division requires the provider to complete a Central Registry screening that verifies the person does not appear on a substantiated Wyoming Department of Family Services Central Registry, per Wyoming Medicaid rules, Chapter 45, Provider Certification and Sanctions. Anytime a participant or their representative self-directing a service chooses to hire a new worker, the Financial Management Service must assure the background check process is completed before the worker can receive reimbursement for working for the participant.

The DD Division requires ABI Waiver provider applicants to complete the Central Registry Screening before they are certified to provide services. To assure the Central Registry Screening is completed the DD Division submits the screening paperwork to the Wyoming Department of Family Services and receives the results of the screenings, which are maintained in the provider file. ABI Waiver Providers employing staff are required to complete the Central Registry Screening for all staff providing direct services at the time of hire. The provider submits the screening paperwork to the Wyoming Department of Family Services and receives the results of the screenings, which are maintained in the individual staff's personnel file. The DD Division completes a staff file review of provider agencies during the provider recertification process to assure the Central Registry Screenings have been completed and to verify that staff meet the screening requirements to provide waiver services.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is**

qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The DD Division within the state Medicaid Agency has continuous open enrollment of ABI Medicaid Waiver service providers. Information on how to become an ABI Medicaid Waiver provider is available on the DD Division's website. When contacted by interested provider applicants, DD Division staff reviews the process and requirements of becoming an ABI Medicaid Waiver provider, including the requirements that the provider sign a Medicaid Provider Agreement, complete background checks, and complete a central registry screening. If DD Division staff meet with the applicant in person the enrollment packet is given to them during the meeting. If the applicant contacts the DD Division by phone an enrollment packet is sent to them by mail. The application is currently not available on-line. DD Division staff work with the applicant throughout the enrollment process, keep the applicant informed of what is still pending, and are available to answer questions. After all requirements of certification have been met, the DD Division forwards the enrollment packet to Affiliated Computer Services Inc. (ACS), the Medicaid billing representative. ACS reviews the enrollment packet to assure the applicant has completed all the required paperwork, including the Medicaid Provider Agreement, and verifies the applicant meets the requirements to become a Medicaid provider. ACS then generates the provider number and notifies the DD Division that the applicant has been assigned a provider number. All providers certified to provide ABI Waiver services are required to have a current provider agreement in place with the State Medicaid Agency.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Proportion of ABI waiver providers meeting all state certification requirements (the number of waiver providers initially certified who meet all the requirements divided by the number of providers initially certified to provide waiver services)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial provider applicant's information entered into IMPROV, the DD Division's provider management system verifying provider applicant has met the requirements to be certified as a provider.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Results of ABI provider application by category (granted initial certification, denied certification – standards not met, denied certification – application incomplete) measured by the number of applicants in each category divided by the total number of waiver provider applicants)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider certification information entered into IMPROV, the DD Division's provider management system verifying the provider has completed the certification process

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI waiver providers completing recertification process by end certification date (the number of providers recertified by end certification date divided by the number of providers certified to provide services on waiver)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Completion date of recertification is tracked in IMPROV, the Division's provider management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI waiver providers who have implemented approved quality improvement plans according to Division standards (the number of waiver providers who have implemented approved quality improvement plans according to Division standards divided by the total number of providers who were required to submit a quality improvement plan)

Data Source (Select one):
Other
If 'Other' is selected, specify:
IMPROV, the DD Division's provider management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI waiver providers found to be non-compliant with certification standards, by standard area and type of provider (the number of providers that received citations resulting in recommendations, by standard area divided by the total number of providers reviewed in the fiscal year by the Provider Support Unit.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Areas of provider non-compliance is tracked in IMPROV, the DD Division's provider management system

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI waiver providers sanctioned due to noncompliance with rules by type of sanction – suspension, civil monetary penalty etc. (the number of

providers sanctioned due to noncompliance with rules divided by the total number of providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
IMPROV, the DD Division's provider management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI participants interviewed who report that they are familiar with the process for filing a grievance and/or complaint regarding a provider (the number of ABI participants who affirm knowing the complaint process divided by the total number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: aggregation of data occurs over two year period but a report is generated annually to analyze significant trends that need to be addressed

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Wyoming does not allow payment to non-certified providers except through the Financial Management Service Fiscal/Employment Agent. Proportion of non-certified providers who are allowed to provide services and receive payment (the number of non-certified providers receiving payment for waiver services divided by the number of providers enrolled as waiver providers.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Division's provider management system, IMPROV

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of ABI waiver providers initially certified who complete initial provider training (the number of new providers receiving training divided by the of new providers initially certified)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial provider training is tracked through IMPROV, the DD Division's provider management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI waiver providers required to complete retraining in a specific area as specified in state requirements and the approved waiver (the number of providers required to complete retraining divided by total number of ABI Waiver providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider retraining is tracked in IMPROV, the DD Division's provider management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI waiver providers receiving recommendations due to provider training not being conducted in accordance with state requirements and approved waiver by type of provider -CARF, non-CARF, (ABI Waiver providers receiving recommendations due to provider training not being conducted in accordance with state requirements by type of provider divided by total number of ABI Waiver providers)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recommendations on provider training tracked in IMPROV, the DD Division's provider management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI participants surveyed that report staff has adequate training to meet his/her needs (the number of ABI participants who affirm staff have adequate training divided by the total number of ABI participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample**

		Confidence Interval = 95% +/- 5%
☑ **Other** Specify: Contractor for National Core Indicators survey	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: aggregation of data occurs over two year period but a report is generated annually

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by

the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Subassurance 1: Qualified providers:

Initial provider certification process

Provider applicants must meet all requirements for the services they are requesting certification in before becoming a certified provider. This information, including results of background checks, CPR certification, First Aid certification, and training, is tracked in the DD Division's provider management system, IMPROV. No provider applicant is allowed to become certified until all required documentation and results of background checks have been received. Data from IMPROV is generated to report on trends within the provider certification process.

2. Provider recertification process

Providers are required to be recertified at least every two years, depending on the results of their current recertification. The recertification process includes verification the provider is complying with rules & regulations pertaining to qualifications for services, staff/provider training, policies, procedures and practices for incident reporting, restraint usage, documentation and billing standards, HIPAA/Confidentiality, emergency procedures, inspections, rights and rights restrictions, and appropriately implementing plans of care. The results of the recertification outline any specific issues of non-compliance, information for submitting quality improvement plans, and specific time lines to remedy non-compliance issues. The DD Division works with providers to ensure compliance is met including providing individual consultation and when necessary, sanctioning the provider due to not adhering to time lines or failure to meet compliance. The results of the recertifications are tracked in IMPROV, including areas of non-compliance resulting in recommendations, dates of submission and approval of quality improvement plans, and verification quality improvement plans have been implemented appropriately. Data is generated from IMPROV to track trends in areas of non-compliance, submissions of quality improvement plans, and completion dates of recertifications.

3. Complaint process

Participants, guardians, and providers can file a complaint against another provider. Complaints received by the DD Division are entered in IMPROV, and follow-up actions are determined based on priority levels according to the type of complaint. If the DD Division determines there is provider non-compliance with rules and regulations through a complaint, the complaint is substantiated and the provider is required to submit a quality improvement plan that is tracked through IMPROV. The Division provides notification to the complainant regarding if the complaint was found substantiated or not substantiated.

4. Incident reporting process

Incidents reported to the Division are tracked through IMPROV, and may result in a criminal case through law enforcement, an investigation by DFS, and/or an investigation by the DD Division. Follow-up actions by the DD Division are based on priority levels and type of incident. If the DD Division determines there is provider non-compliance with rules and regulations through complaints or incidents the complaint or incident is "substantiated" and the provider is required to submit a quality improvement plan that is tracked through IMPROV.

5. Internal referral process

Division staff who attend team meetings or review and approve plans of care may identify provider non-compliance with rules and regulations through one of these processes. When this occurs, DD Division staff submit an internal referral through IMPROV, and follow-up actions are determined based on priority levels type of the internal referral. If the DD Division determines there is provider non-compliance with rules and regulations, the internal referral is substantiated and the provider is notified by the Division to submit a quality improvement plan that is tracked through IMPROV.

If a provider repeatedly fails to submit an acceptable quality improvement plan the Division has the authority to sanction the provider. Sanctioning can include freezing a provider's admissions, suspending a provider, imposing a monitor, imposing a civil monetary penalty, removing participants at significant risk, requiring additional training, decertifying a provider, as well as other sanctions. Information on providers who have been sanctioned is tracked in IMPROV and data generated on sanctions. Providers can also be decertified if they are convicted of a crime against a person or if they are listed on the Abuse Central Registry.

Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
The DD Division assesses providers' adhering to training requirements through the same processes listed above. A provider applicant is not certified as a provider until they have completed the required training. All certified providers are then responsible for ensuring that they have had participant specific training prior to working with a participant for all waiver participants they are providing services to. If concerns with provider training are found through one of these processes discussed previously, the provider is required to submit a quality improvement plan addressing the non-compliance with in regards to training. The provider is responsible for receiving training within the time frames specified in the quality improvement plan. In addition, the Division also has the authority to require a provider to complete retraining in a specific area when concerns continue to be identified. This information is tracked through IMPROV and reports are generated on the number of providers requiring retraining, the number of providers receiving recommendations concerning training, and the number of new providers who completed the required training.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

The DD Division limits the maximum dollar amount of waiver services authorized for each ABI Waiver participant using a prospective individual budget amount. The prospective individual budget amount is based upon historical annual plan units multiplied by the posted service rates. The rates for all ABI Waiver services are posted on the DD Division website. For new participants, the limit is based upon core services multiplied by projected units as determined using the ICAP assessment and information from the case manager to determine service needs.

Participants, guardians and case managers are notified by letter of a participant’s individualized budget amount when the participant is provided a funding opportunity on the ABI Waiver, and whenever there are changes to the individualized budget amount. The budget limit methodology may be adjusted over the course of the waiver period due to increases or decreases in posted rates and/or increases or decreases in funding appropriations.

Once the individualized budget is first determined or is changed, the participant, the case manager and the team work together to develop or revise the plan of care so that needed waiver services are allocated within the individualized budget and non-waiver services are identified. The individualized budgeted amount does not limit specific waiver services. If the participant and/or guardian, with support from the team, identifies that the plan of care developed within the budgeted amount will not meet the participant’s health and welfare needs the case manager can request additional funding on behalf of the participant through the DD Division’s Extraordinary Care Committee.

The DD Division’s Extraordinary Care Committee has the authority to evaluate and approve requests for additional funding above a participant’s individualized budget amount due to emergency requests, a material change in circumstance, a potential emergency or other condition justifying an increase in funding. Requests to review individual budget amounts or appeals of individual budget amounts are reviewed within ten (10) working days upon receipt of all additional requested information. The Case Manager will be informed of the decision by letter within ten (10) business days of the decision. The Extraordinary Care Committee’s membership includes the Waiver Manager, the DD Division's Fiscal Manager, and a representative of the State Medicaid Agent. The committee reviews the ECC request and information compiled by the participant’s case manager, which must detail the reasons for the needed increase in funding and an explanation for the person’s specific health and welfare needs not being adequately addressed within the individualized budgeted amount or through other non-waiver resources or supports. In some instances, the participant may be denied additional funding but may be directed to enroll in other

available programs or resources to meet his/her needs in lieu of waiver funding. In these cases the participant and/or guardian is notified by letter they have a right to request a fair hearing.

The process for determining a participant's individualized budgeted amount is made available through a memorandum to stakeholders, which includes participants, guardians, and providers. An ECC database is maintained by the DD Division, which summarizes the decision of all requests, including if the decision and funding is time-limited. The ECC policy, procedure and forms for requesting additional funds are available on the Division's website for public viewing and use.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individualized Plan of Care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker.**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The DD Division reviews and approves 100% of plans of care developed and submitted by case managers. Part of this review and approval process is assuring the plan has been developed in the best interests of the participant and identifies appropriate services and supports based on the input from the participant, guardian and family. Participants and guardians are required to sign each plan of care verifying they agree with the services, supports in the plan and have had the opportunity to have informed choice of providers.

In addition to these safeguards, the DD Division has implemented policies to specifically address conflicts of interest when case managers are providing other services on the plan.

1) The DD Division has developed a process for certifying case management providers working with organizations under their own provider number. This process provides case managers with the autonomy and authority to develop the plan of care in the best interest of the participant. This process also provides the DD Division with the authority to sanction and, if necessary, decertify case managers who fail to serve in the best interest of the participant.

2) The DD Division has enhanced its education of participants/families and guardians initially applying for services and developed a participant handbook that is distributed to all participants/families and guardians. This handbook explains the role of the case manager in assuring participants have choice of providers, the responsibilities case managers have in assuring the development of the plan of care is in the best interest of the participant and responsibilities case managers have in monitoring the implementation of the plan of care to assure it is implemented in the best interest of the participant. The handbook includes information on actions the participant and guardian can take if there are concerns with a case manager who is also providing other services on the plan of care.

3) The DD Division has developed ongoing training of participants/families and guardians on the ABI Waiver, including:
* available services both in the institution and in the community on the ABI Waiver
* using a person-centered approach to plan for services and to make changes when needed
* the purpose of a plan of care team meeting
* freedom of choice of providers including case managers
* responsibilities of case managers in developing the plan of care, monitoring implementation of the plan of care, and the conflict of interest that occurs when a case manager is providing other services on the plan of care
* participants and guardians roles and responsibilities in development of the plan of care, including participating in plan of care team meetings
* recognizing and reporting abuse, neglect and exploitation

Trainings are offered individually with participants when needed, regionally throughout Wyoming, and upon request.

4) A conflict of interest statement is included in the plan of care asks the team to summarize how the conflict of interest will be addressed, if applicable to the participant, how the best interest of the participant is assured, how monitoring will be enhanced, and what actions the participant and/or guardian should take if he/she has concerns with any aspects of the case manager's roles and responsibilities. DD Division staff serve as a resource to case managers' and the participants' teams to educate them on conflicts of interest, and the responsibilities the case manager has in choice, development of the plan of care, and monitoring implementation of the plan of care.

5) The DD Division requires agencies providing case management, case managers employed by agencies, and self-employed case managers providing other services on plans of care to develop and implement a comprehensive conflict of interest policy that addresses the areas of choice, development of the plan of care and implementation of the plan of care.

6) The DD Division requires comprehensive case management policies on how agency or self-employed case

manager will follow up and provide feedback on concerns identified during development or monitoring of plan of care.

7) The DD Division has developed a web-based complaint process so participants, guardians and families can file a complaint easily with the DD Division if they have concerns. The web-based system provides another avenue for participants, families and guardians to file a complaint at any time as long as they have access to the Internet. The DD Division will still accept written complaints or complaints by phone, whichever is most convenient for the complainant.

The DD Division continues to review 100% of annual plans of care. The review and approval process for plans of care includes a review of the conflict of interest information required in the plan to assure that conflicts of interest are adequately identified and addressed in the plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The DD Division requires and promotes a person-centered approach to services. This support begins when a person applies for the ABI Waiver and is contacted by DD Division staff who explain the participant's important role in the planning process, and continues through decision of whether to self-direct services, choosing of providers, development of the plan of care, and implementation of the plan of care. Waiver eligibility and enrollment staff from the DD Division contacts each ABI Waiver applicant in person or by telephone to explain the application process and to provide information on both home and community-based and institutional services available so the applicant can make an informed choice between institutional or community based services. DD Division staff also provide applicants with an overview of the person-centered process and the option to self-direct services, emphasizing the person has choice of who participates on their plan of care team, which providers they choose, and which waiver and non-waiver services are identified in the plan of care. This information is also summarized in a handbook distributed to applicants either in person or by mail.

If the person chooses community based services and once there is a funding opportunity, the DD Division generates the budget limit amount and notifies the participant and/or guardian of the funding opportunity and of their budgeted amount. The case manager reviews the array of services on the ABI Waiver, including the option to self-direct support services. If the participant or their representative chooses to self-direct services, the case manager works with them to choose a Support Broker, who will assist them in all aspects of self-direction as needed. If the participant chooses to receive traditional provider services, the case manager reviews the list of providers in the community that provide the needed services. The participant and guardian inform the case manager of the people they would like to have involved in their circle of support.

The participant's circle of support are family members, friends, providers, therapists, direct care staff, and other natural support people who the participant and/or guardian identifies as a network of people who assist the person in routine life areas. If self-directing, the support broker helps the participant's team (circle) in identifying the non-waiver and waiver services, which are available and needed in the participant's life. If choosing traditional services, the case manager works with the participant and the circle of support to develop a plan of care that includes natural supports, non-waiver services, and waiver services needed to assist the person in achieving their personal goals. The participant, guardian, and team inform the case manager of times they are available to meet to develop the plan of care. The case manager then schedules the meeting, notifying the team members.

For those who choose to self-direct some services and choose traditional services for others, the participant shall receive help from both the support broker and the case manager on reviewing the providers and services available in his/her area and developing a team of support and services that are most appropriate, available, and needed in the person's life.

If the participant and/or guardian are not certain of which services are the most appropriate, the case manager will schedule a team meeting to begin developing the plan allowing the participant to understand the waiver and non-waiver service options.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Once an applicant on the ABI Waiver receives funding, the DD Division generates the individualized budget amount and notifies the participant and/or guardian of the funding opportunity and of the individual budgeted amount. The case manager reviews the array of services on the ABI waiver and the list of providers in the community that provide these services. The participant and guardian inform the case manager of the people they would like to have involved in the participant's plan of care team, including providers, and of times they are available to meet to develop the plan of care. The case manager then schedules the meeting, notifying the team members.

During the team meeting the participant, the case manager and the team work together to develop a plan of care that will allocate the individual budget amount for needed waiver services and that identifies non-waiver services available and appropriate for the participant. These non-waiver services may include Medicaid State Plan Services, housing, community services offered through grants or other programs, and natural supports.

During the team meeting the case manager reviews information, as appropriate, from the psychological evaluation, ICAP assessment, medical history, behavioral reports, recent medical appointments or therapeutic assessments completed. This information is used throughout the plan of care to assure health, safety, risks and support needs are addressed in the plan.

The plan of care begins with an "About Me" section, which specifically asks questions to actively engage the participant to develop the integral components of the plan of care. Their responses to the questions gather input on the participant's accomplishments, progress, wishes, wants, dreams, likes, dislikes, plans for the future, etc. The participant's team assists the participant in selecting appropriate services, capturing personal goals, developing meaningful objectives, constructing individualized daily service schedules, and developing realistic, positive behavioral and or medical treatment plans as needed.

The next section of the plan of care covers the participant's rights and rights restrictions. If rights restrictions are imposed, the team is required to identify the reason for the restriction, how it is imposed, and how the participant can exercise their rights more fully. The team is also required to identify when the rights restrictions will be reviewed for continued appropriateness. The maximum time frame between reviews is at least every six months, or as needed.

The plan of care also contains a section on medical information that includes a list of the participant's medical specialists, current medications, information on seizures, current adaptive or specialized equipment, and any other health information pertinent to the delivery of services. It is noted in this section that the case manager must update this information in the plan of care as needed, and distribute the revised information to the plan of care team, including all providers. Examples of changes may include a change in medication, purchasing a new piece of specialized equipment, a change in seizure activity requiring a revised seizure protocol.

The next sections of the plan of care cover specific support needs the participant has in different settings, including at home, in the community, and at work. These sections also cover the participant's supervision needs and level of assistance needed with activities of daily living, measurable and meaningful objectives the participant has chosen to work on and behavior support needs. A Positive Behavior Support Plan is required if the individual exhibits a behavior of moderate or above on the ICAP assessment or if the team identifies any significant behavioral issues. Throughout these sections, the plan identifies specific risks and safety plans to address the risks.

A final signature page concludes the plan of care, and all parties signing the form confirm that the plan of care has been carefully planned and coordinated with the active involvement of the participant and guardian. The signatures

also assure the plan has been individually tailored, identifying appropriate waiver and non-waiver services, and establishing schedules, activities, and objectives that incorporate the participant's unique needs and preferences. The plan specifically states "I have been present, encouraged, and involved at every possible level during the development of my plan of care," therefore, by signing the plan the participant or guardian verify their involvement in the development of the plan.

The case manager is responsible for completing the initial plan of care based on the input from the participant, guardian and team. The initial plan of care must be submitted to the DD Division for review and approval within 45 days of receiving notification of funding. Annual plans of care for existing participants are due to the DD Division for approval 30 days before the next plan start date.

Once the plan is approved by the DD Division, case managers have specific monitoring responsibilities to assure the plan of care is being implemented appropriately and to identify possible changes needed in the plan. These responsibilities include:
• Completing a monthly home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with both waiver and non-waiver services and needed changes to the plan of care with the participant.
• Observing the delivery of services to the participant quarterly
• Reviewing critical incidents that have occurred monthly to identify trends and concerns
• Reviewing progress on objectives monthly
• Reviewing implementation and effectiveness of the positive behavior support plan monthly
• Reviewing restraint usage and restrictive interventions monthly, following up as needed, and reporting restraint and restriction data quarterly
• Reviewing utilization of services and documentation of service delivery monthly
• Reviewing health and welfare information quarterly to identify possible changes in health status

If the case manager identifies concerns with either the existing plan of care meeting the needs of the participant or with the implementation of the plan of care, the case manager is responsible for working with the participant, guardian and team, including holding a team meeting, to address the concerns and revise the plan of care as needed.

In addition to the specific responsibilities listed above, the case manager is also required to coordinate a six month plan of care review meeting where the participant, guardian and team formally review the effectiveness of the implementation of the plan of care and identify changes needed. The case manager is required to review specific information from implementation of the plan of care over the past six months, including a summary of progress on objectives, changes in health status, restraint and restrictive interventions occurring over the past six months, utilization of services, and other health or welfare concerns. The team identifies possible changes to the plan of care and the case manager is responsible for updating the plan based on this information.

Team members can also request a team meeting at any time to review the plan of care, request changes, or discuss concerns. If a participant is denied a service they are requesting or is denied choice of providers, they are notified of the opportunity of a Fair Hearing.

Rules for the plan of care development process are found in Wyoming Medicaid Rules, Chapter 43, ABI Waiver rules, and DD Division Rules, Chapter 1, Case Management rules.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The individualized plan of care (IPC) developed by the participant's team must have input from the participant in the "About Me" section on things the participant likes, wants in their life, and does not want in their life. Through these series of questions, the plan of care form has cues for the case manager to facilitate conversation about unhealthy habits, risky behavior, and important changes the person wants to make in their life.

To further expand upon the input from the participant and guardian on risks in the "About Me" section, the DD

Division uses the Supports, Medical Information, and Positive Behavior Support plan sections of the IPC to address risks and construct support plans. The functional limitations, identified risks and support needs of the participant are outlined in the areas of Communication, Self-Advocacy, Transportation, specific safety supports needed, Near Water, Community Outings, Mobility, Monitoring needed during sleeping, Money transactions, Mealtime guidelines, Dietary, Emergency situations, Toileting, Personal Hygiene, Home Supervision, Positioning, and Day Site Supervision. Special protocols for any critical medical, safety, or behavioral need is expanded upon through a separate attached protocol.

For behaviors identified as potentially risky or historically risky to a person's health or safety, a carefully designed positive behavior support plan is required to mitigate risk. It is based on a functional behavior analysis of the participant's specific behaviors, antecedents, communication style and obstacles, stressors, rewards, and environmental factors. The requirements for developing and implementing a positive behavior support plan are in Chapter 45, Section 29 of the Medicaid Rules for Provider Certification.

To address the need for backup plans and the arrangements used for backup, the DD Division has revised the plan of care to include a section on "Backup support plans". In this section, the participant's team will review the circle of support the participant has to identify the first line of communication when the participant is in an emergency or in need of quick assistance to resolve an issue or conflict. The team will also identify who the main contact people are in the person's routine activities and environments, in case an incident arises. For individuals who live semi-independently or independently with monitoring, the plan will include a more detailed action plan for on-call or emergency situations.

In order to develop an on-call system of both natural and provider supports, the participant's team will evaluate the person's unique needs and circumstances to determine the situations that may arise where the participant may need to call someone in their "circle" for back up. These situations may include: housing issues, police involvement, money concerns, food shortages, transportation problems, witnessing criminal behavior, staff/provider problems, behavioral concerns, medical concerns and/or medical emergencies, and any other identified potential risky situations. After identifying the situations pertinent to the participant, the team will develop a contact person for the situation, and the criteria for which the situation will rise to the "on-call response" level. The backup support plan will be implemented by training all on-call contacts on the plan, teaching the participant the plan and reviewing/reteaching it as needed, posting it in a visible area for the participant, and revising it as needed. The plan will be reviewed at least every six months at the semi-annual review of the plan of care meeting, and at the annual plan of care development meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

ABI Waiver participants and guardians have free choice of providers and can request a change of providers, except case managers, at anytime during the plan year. The DD Division reviews information on provider choice when a person first applies for services on the ABI Waiver, including the option to self-direct services and to be the employer of record or co-employer. When an applicant receives a funding opportunity, the case manager is required to review the types of services available, the list of service providers, and to emphasize the importance of choosing providers that will meet the applicant's needs. The case manager is also required to review choice of providers during each six month plan of care review meeting and before the annual plan of care meeting, so the participant has an opportunity to change providers before the new plan is developed.

The current provider list is available through the participant’s case manager and is on the DD Division’s website in a searchable format so people can search for providers certified to provide a specific service in a geographic area. The individual plan of care includes a check box where the participant or guardian signs verifying they understand they have free choice of providers. DD Division staff review 100% of the annual plans of care, including this section, to assure it is signed and dated.

Once a participant chooses to change providers, they notify their case manager, who is required to follow a specific transition process, including scheduling a team meeting that includes the participant, guardian, other chosen team members, and both the current and future provider. This is to ensure the future provider is given all the pertinent information on the participant and the plan of care, and is involved in revisions to the plan of care as needed.

ABI Waiver participants can choose to change their case manager during the six month plan of care review process or the annual plan of care development process. This restriction to changing case managers is in place to assure there is consistent monitoring of the implementation of the plan of care and changes are made to the plan of care as needed. However, participants or guardians can request that the DD Division permit a change of case manager at other times if there is a significant conflict between the participant and case manager, evidence of unethical conduct, non-performance of duties, resignation of the case manager, or other unusual circumstances. If the participant or guardian is denied the request to change, they may request a Fair Hearing. In cases where there is evidence of unethical conduct or non-performance of duties, a referral is made to the Provider Support unit within the DD Division to investigate the "complaint." If the complaint is substantiated, the case manager is required to complete a quality improvement plan addressing the non-compliance with case management requirements.

The DD Division maintains a listing of all providers that can be searched by town or by service type on its website. The Notice to Change Case Manager form, Transition Checklist, and listing of providers can be found on the DD Division's website http://www.health.wyo.gov/ddd. Information on participant transitions can be found in Medicaid Rule Chapter 45, Section 31.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The DD Division is a part of the state Medicaid Agency, so it is not necessary to fill this section out.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The first line of monitoring the implementation of the plan of care is the participant's case manager, who is responsible for completing the following monitoring activities:
• Completing a monthly home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with both waiver and non-waiver services and needed changes to the plan of care with the participant.
• Observing the delivery of services to the participant quarterly
• Reviewing critical incidents that have occurred monthly to identify trends and concerns
• Reviewing progress on objectives monthly
• Monitoring back up plans monthly
• Reviewing implementation and effectiveness of the positive behavior support plan monthly
• Reviewing restraint usage and restrictive interventions monthly, following up as needed, and reporting data quarterly to the DD Division
• Reviewing utilization of services and documentation of service delivery monthly
• Reviewing status of self-directed services, including Support Brokerage services on a monthly basis, including budget utilization
• Reviewing health and welfare information quarterly to identify possible changes in health status

The case manager is required to document these monitoring activities, completing follow-up on concerns, document the follow-up actions completed, and make appropriate changes to the plan of care with team involvement when needed.

For participants self-directing services the Support Broker is required to assist the participant or their legal representative in assessing how services are going, in monitoring the utilization the individual budget, and is responsible for working with the participant and case manager when concerns arise.

For participants self-directing services through the Financial Management Service - Fiscal/Employer Agent, the DD Division has identified flags that will identify possible concerns with utilization of services and supports so the Financial Management Service -Fiscal/Employer Agent can address the concerns. These flags include significant under utilization of services, significant over utilization of services, purchases of goods and services over a specific dollar amount, significant concerns with hiring/firing of workers or with workers' time sheets. When these situations occur the Financial Management Service - Fiscal/Employer Agent are required to notify, as appropriate, the participant or their legal representative, the participant's case manager for follow-up, and the DD Division.

For participants self-directing services through an Financial Management Service - Agency with Choice provider, the DD Division has identified flags that will identify possible concerns with utilization of services and supports. These flags include significant under utilization of services, significant over utilization of services, significant concerns with hiring/firing of workers or with workers' documentation of services. When these situations occur the Financial Management Service - Agency with Choice provider will be required to notify, as appropriate, the participant or their legal representative, the participant's case manager for follow-up, and the DD Division.

The DD Division is responsible for monitoring the implementation of the individual plan of care, including monitoring participant health and welfare. The unit completes this monitoring for a representative sample of participants on the ABI Waiver. The representative sample size has a 95% confidence level and a margin of error of 5%. The representative sample is identified in July of one year and the review of the implementation of the plans of care will be completed throughout two fiscal years, and will focus on the implementation of the entire plan of care, including non-waiver services, not just on specific providers. The review includes, when applicable and appropriate, observations of all waiver services, review of non-waiver services, review of adequacy of backup plans, interviews with the participant, provider staff, and guardians, walk through of service areas, review of case management documentation, and review of all other pertinent documentation. The focus of these reviews will be to assure participants have access to the services in their plan, that the services meet the needs of the participants, participants have access to non-waiver services in their plans, and participants' health and welfare needs are being met.

The review will also include review of case management documentation for ABI Waiver participants for a six month period to verify the case manager is consistently monitoring the implementation of plans of care and updating the plan as needed.

In addition to reviewing the implementation of the plan of care for the representative sample, the DD Division also monitors service plan implementation through the following processes:

1) Provider recertification process:
Providers are initially certified for one year and are required to complete a recertification at the end of the first year. After the initial year certification, the DD Division can certify an agency for up to two years. Agencies who receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights, habilitation, or have few recommendations in other areas reviewed receive up to a one year recertification, and agencies who do not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights, habilitation, or have multiple recommendations in other areas reviewed receive a two year recertification.

2) Incident reporting process:
The DD Division requires providers report specific categories of incidents as described in the incident reporting section of this application. The unit reviews each incident reported within one business day to determine if there are significant health, safety or rights concerns, including concerns with the implementation of the plan of care. These are considered level one incidents and require follow-up within ten business days. The review also includes verification the provider reported the incident to all appropriate entities and completed the appropriate follow-up actions based on the incident. If there are concerns with the incident and/or follow-up completed by the provider, DD Division staff complete followup actions to assure the concerns are addressed. If the complaint is not considered a level one complaint, DD Division staff complete an investigation and/or other follow-up actions to determine if the complaint is substantiated, following the timelines below:
Level 2 – Medium Consideration: Person's health or safety is of significant concern and provider compliance needs to be ensured. This requires follow-up actions by the DD Division within two weeks.
Level 3 – Lower Consideration: Although no substantial health and safety concerns, the incident may impact the care of the person and provider compliance needs to be ensured. This requires follow-up actions by the DD Division within 2 weeks-1 month.
NAN – No Action Necessary: Adequate information and follow up have been provided. No concerns with health/safety and no compliance must be ensured.

3) Complaint process:
The DD Division manages the complaint process, described in the Grievance/Complaint section of this application. Anyone can file a complaint with any DD Division staff, and the complaint is referred to the appropriate DD Division staff who first determines if the complaint identifies significant health, safety or rights concerns. These are considered level one complaints and require initial follow-up within two business days. If the complaint is not considered a level one complaint, DD Division staff complete an investigation and/or other follow-up actions to determine if the complaint is substantiated, following the timelines below:
• Level 2 – Medium Consideration. Complaint identifies potential provider non-compliance that may be impacting the

quality of services participant is receiving. Investigation must be completed with 30-60 days.
• Level 3 – Lower Consideration: Complaint indicates potential provider non-compliance that does not appear to be directly impacting the quality of services to the participant. Investigation must be completed within 90 days.
• NAN – No Action Necessary: Complaint is either outside the scope of the DD Division and the complainant is notified of who may have authority to investigate or the complaint does not identify any compliance issues that can be investigated.

4) Internal DD Division referrals:
DD Division staff can make an internal referral to the appropriate staff when they identify possible concerns with a participant's health, welfare, delivery of services, or rights. DD Division staff first work with the provider to resolve these concerns, unless there are significant health or safety concerns, which results in an immediate follow-up on the concerns. DD Division staff complete the appropriate follow-up actions or investigation to assure the situation is addressed appropriately. Significant health or safety concerns are considered level one internal referrals and require initial follow-up within two business days. If the internal referral is not considered a level one referral, DD Division staff complete an investigation and/or other follow-up actions to determine if the internal referral is substantiated, following the timelines below:
• Level 2 – Medium Consideration. Internal referral identifies potential provider non-compliance that may be impacting the quality of services participant is receiving. Investigation must be completed with 30-60 days.
• Level 3 – Lower Consideration: internal referral indicates potential provider non-compliance that does not appear to

be directly impacting the quality of services to the participant. Investigation must be completed within 90 days.
• NAN – No Action Necessary: internal referral is either outside the scope of the DD Division and the DD Division staff is notified of the reason no action is being taken on the referral.

When significant health or safety concerns are identified through any of the above processes, DD Division staff completes an initial contact with the provider within two business days to assure the immediate health and safety risks are addressed by the provider and the significant health and safety concerns have been abated. This initial contact may include an on-site visit and/or review of documentation from the provider.

If non-compliance with rules and regulations is substantiated through any of the above processes, including situations where significant health and safety concerns have been identified, the provider is required to submit a quality improvement plan that includes specific action steps, responsible parties, and time frames for completing each step. If health, safety or rights concerns are substantiated the provider must submit the plan within 15 business days. All other plans must be submitted within 30 calendar days. The DD Division must approve the plan, and monitors the implementation of the plan to assure it has adequately addressed the area of non-compliance.

If the DD Division determines a participant or participants are in imminent danger, or if there is evidence of abuse or neglect, the DD Division can require the provider to make accommodations to protect the participant(s), up to and including moving the participant(s) to a different provider of the the participant's choice. In these cases, an emergency team meeting is held and participants are provided with a list of current providers that they may choose from.

Failure to address areas of non-compliance can result in sanctioning by the DD Division, including suspending the provider, freezing admissions, or decertifying the provider. The Provider Support unit of the DD Division enters and tracks information on these monitoring processes in IMPROV, the DD Division's provider management system. All DD Division staff, the Medicaid Liaison, and Medicaid's Program Integrity Manager have access to IMPROV and can view incident reports, complaints, internal referrals, as well as results of providers' recertification, so they can track the follow up on specific situations and add information as appropriate. The DD Division reviews data on these processes generated from IMPROV monthly and quarterly to identify significant trends that may need action before the formal annual data analysis is completed as described in Section H of this application. The Participant Support Manager and appropriate DD Division staff are notified of all incidents and complaints involving ABI Waiver participants so they are aware of what has occurred, can provide input and guidance on the follow-up actions, and can track the follow-up on the incidents and complaints through IMPROV. The Medicaid Program Integrity Manager, who reports directly to the State Medicaid Agent, is notified of all level one complaints or incidents and is involved as appropriate on identifying follow-up actions to be taken. The Medicaid Program Integrity Manager is also notified of providers who are at the point of being sanctioned, and tracks the sanctioning process to assure all appropriate steps have been taken with the provider.

b. Monitoring Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The DD Division monitors case managers through the processes described in D-2-a. These processes include the recertification process, incident reporting process, complaint process and internal referral process.

The case manager is responsible for completing the following monitoring activities on a monthly basis: a monthly home visit, observation of services, review of documentation/billing from all service providers on the plan, review of incidents and restraints, review of progress on training objectives, review of implementation of the positive behavior support plan, and interviews with the participant and guardian that include specific questions on satisfaction of services, identification of what is going well and what concerns exist. The case manager is required to complete a quarterly review of all of the above information to identify trends, and to respond to specific questions on whether significant changes have occurred relating to the participant's health, behavior needs, or any other significant changes. The case manager is also required to interview the participant and/or guardian to assess satisfaction with where they live, where they work, or, if they don't work, if they would like to work. The case manager is responsible for documenting these monitoring activities, completing follow-up on concerns, documenting the follow-up actions completed, and making appropriate changes to the plan of care with team involvement when needed.

The DD Division reviews case management documentation to assure these monitoring activities are being completed and concerns addressed.

The DD Division reviews and approves 100% of plans of care developed and submitted by case managers. Part of this review and approval process is assuring the plan has been developed in the best interests of the participant and identifies appropriate services and supports based on the input from the participant, guardian and family. Participants and guardians are required to sign each plan of care verifying they agree with the services, supports in the plan and have had the opportunity to have informed choice of providers.

In addition to these safeguards, the DD Division has implemented policies to address specifically address conflicts of interest when case managers are providing other services on the plan.

1) The DD Division has developed a process for certifying case management providers working with organizations under their own provider number. This process provides case managers with the autonomy and authority to develop the plan of care in the best interest of the participant. This process also provides the DD Division with the authority to sanction and, if necessary, decertify case managers who fail to serve in the best interest of the participant.

2) The DD Division has enhanced its education of participants/families and guardians initially applying for services and developed a participant handbook that is distributed to all participants/families and guardians. This handbook explains the role of the case manager in assuring participants have choice of providers, the responsibilities case managers have in assuring the development of the plan of care is in the best interest of the participant and responsibilities case managers have in monitoring the implementation of the plan of care to assure it is implemented in the best interest of the participant. The handbook includes information on actions the participant and guardian can take if there are concerns with a case manager who is also providing other services on the plan of care.

3) The DD Division has developed ongoing training of participants/families and guardians on the ABI Waiver, including:

* available services both in the institution and on the ABI Waiver
* using a person-centered approach to plan for services and to make changes when needed
* the purpose of a plan of care team meeting
* freedom of choice of providers including case managers
* responsibilities of case managers in developing the plan of care, monitoring implementation of the plan of care, and the conflict of interest that occurs when a case manager is providing other services on the plan of care
* participants and guardians roles and responsibilities in development of the plan of care, including participating in plan of care team meetings

Trainings are offered individually with participants when needed, regionally throughout Wyoming, and upon request.

4) A conflict of interest statement is included in the plan of care that summarizes how conflict will be addressed, how the best interest of the participant is assured, how monitoring will be enhanced, and what actions the participant/guardian should take if he or she has concerns with any aspects of the case manager's roles and responsibilities. DD Division staff serve as a resource to case managers' and the participants' teams to educate them on conflicts of interest, and the responsibilities the case manager has in choice, development of the plan of care, and monitoring implementation of the plan of care.

5) The DD Division requires agencies providing case management, case managers employed by agencies, and self employed case managers providing other services on plans of care to develop and implement a comprehensive conflict of interest policy that addresses the areas of choice, development of the plan of care and implementation of the plan of care.

6) The DD Division requires comprehensive case management policies on how agency or self-employed case manager will follow up and provide feedback on concerns identified during development or monitoring of plan of care.

7) The DD Division has developed a web-based complaint process so participants, guardians and families can file a complaint easily with the DD Division if they have concerns. The web-based system provides another avenue for participants, families and guardians to file a complaint at any time as long as they have access to the Internet.

The DD Division continues to review 100% of annual plans of care. The review and approval process for plans of care includes a review of the conflict of interest information required in the plan to assure that conflicts of interest are adequately identified and addressed in the plan.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of ABI Plans of Care in which the individual's assessed needs align with the services and supports (the number of plans in which the individual's assessed needs align with the services and supports divided by the total of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI Plan of Care Excel spreadsheet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI Plans of Care in which identified risks align with appropriate supports and accommodations (the number of plans in which identified risks align with appropriate supports and accommodations divided by the total number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI Plan of Care excel spreadsheet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI Plans of Care that reflect the individual's personal goals (the number of plans that reflect the individual's personal goals divided by the total number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI Plan of Care excel spreadsheet

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Proportion of ABI Plans of Care with participant and/or guardian signature verifying they participated in the development of the plan (the number of plans with signature affixed divided by the number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI Plan of Care excel spreadsheet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

☐ **Continuously and Ongoing**	
☐ **Other** Specify:	

Performance Measure:
Proportion of ABI participants with restraint usage authorized in the plan of care (the number of participants with restraint usage in the plan divided by the number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI Waiver access database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI participants who report their case manager is accessible, responsive, and supports their participation in service planning (the number of participants who report their case manager is accessible, responsive, and supports their participation in service planning divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☑ **Other** Specify: contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Interviews are completed over a two year period to obtain a representative sample. A preliminary report is

		compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: aggregation of data occurs over two year period but a report is generated annually

Performance Measure:
Proportion of ABI participants interviewed who report that they were involved in the development of the plan of care (the number of participants interviewed who affirm in response to this question divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample**

		Confidence Interval = 95% +/- 5%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: aggregation of data occurs over two year period but a report is generated annually

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of ABI Plans of Care requiring correction to be consistent with state policies and procedures by category (approved with no changes, correction needed by type of correction)(measured by the number of plans in each results category divided by the total number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Plan of Care excel datasheet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data	**Frequency of data aggregation and**

aggregation and analysis *(check each that applies):*	**analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of ABI Plans of Care that were updated/revised within 365 days of the last plan (the number of plans updated or revised within 365 days of the last plan divided by the total number of plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI Waiver access database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI participants who report that they are getting the services they need (the number of participants who affirm in response to this question divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other**

	Specify: Aaggregation of data occurs over two year period but a report is generated annually

Performance Measure:
Proportion of ABI Plans of Care updated when changes are warranted (the number of plans updated when needed divided by the of participants' case managers' documentation reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Results of case management file review tracked in IMPROV, the DD Division's provider management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: The file reviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: A preliminary report is compiled the 1st year so significant trends can be identified. A final report is completed the 2nd year identifying significant trends based on the representative sample.

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of ABI Plans of Care in which services and supports are provided in the type, scope, amount, duration, and frequency specified in the plan (the number of plans in which services and supports are provided in the type, scope, amount, duration, and frequency specified in the plan divided by the total number of plans reviewed)

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: The record reviews and interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: The record reviews and interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: A preliminary report is compiled the 1st year so significant trends can be identified. A final report is completed the 2nd year identifying significant trends based on the representative sample.

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and***

between/among waiver services and providers.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of approved ABI Plans of Cares that verify the participant and guardian had choice offered - both choice of institution and provider choice (the number of plans with verification divided by the total number of plans approved)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI Plan of Care excel spreadsheet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI participants interviewed stating they were given choice of providers and services (the number given choice divided by the number interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Interviews are completed over a two year period to obtain a representative

		sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: aggregation of data occurs over two year period but a report is generated annually

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Sub-Assurance #1 & 2:

DD Division staff review 100% of plans of care, following detailed plan of care instructions that are available to all providers on the Division's website. The plan of care includes sections on health and safety risk assessments, safety plans to address risks, personal goals, non-waiver services, medical information, behavior plans, and other supports needed either by the provision of waiver service's or through other means. The DD Division's review and approval process includes verification that the plan adequately addresses these areas, the participant and guardian actively participated in the development of the plan, and the plan was developed in accordance with state policy and procedures. The case manager is required to correct incomplete or incorrect

sections of the plan of care before receiving DD Division approval. DD Division staff enters information on the incomplete or incorrect sections of the plan into a plan of care spreadsheet, and this data is reviewed quarterly and analyzed for trends.

Sub-Assurance #3:
The DD Division requires in rule that all plans of care are:
• Approved annually by the DD Division,
• Updated as warranted by changes in the participant's needs
Changes to the plan of care primarily occur through the team meeting process and case managers are required to maintain team meeting notes for each meeting. If a change is requested by the participant, guardian or other team member at a time other than at the annual or six month review, a team meeting must be held to discuss the change. If the change is agreed upon, the case manager modifies the plan of care, and when required, submits the modification to the DD Division. The DD Division conducts case management record reviews during the provider recertification process. If it is discovered that the participant did not have a six month review meeting or a team meeting as needed for a specific change in the plan, it will be noted in the recertification report and a Quality Improvement Plan will be required.
Case managers are required to complete a review of the implementation of the service plan monthly, and a more in depth review quarterly, to ensure a participants needs, wants, health, safety, and satisfaction with services are being assessed for possible service plan changes. Record review of the case manager's monthly and quarterly case notes are performed during the recertification process or as warranted by incident reports or complaints. If the case manager is not meeting the monitoring and documentation requirements they must submit a Quality Improvement Plan to address the identified concerns.
The DD Division keeps track of participants' plans that are due each month to assure plans are updated annually. If a plan is not submitted on time, the case manager is notified within two days to inquire about the tardiness of the plan submission and work with the case manager on a deadline for submission. Late plan submission by a case manager is noted in the person's provider file, and if the problem continues, it is a certification issue with the provider, which requires a Quality Improvement Plan.
The date the plan is approved is noted by the DD Division in a plan of care spreadsheet and in the waiver access database. If a lapse in services occurs due to the delayed start date, then the DD Division works with the case manager to assure the health and safety of the participant until the plan is approved and services can be reimbursed.

Sub-Assurance #4:
The DD Division assesses the implementation of plans of care by completing a thorough assessment of services received by a representative sample of ABI participants. This review includes a review of provider documentation of services, observations of service delivery to assure it meets the requirements in the plan of care, review of utilization and claims for services, and provider compliance with the state rules and standards. Information on the results of the monitoring is tracked in IMPROV, including specific concerns that must be addressed by the case manager and/or provider. If a deficit is discovered, then a quality improvement plan is required by the provider to address the area of non-compliance.

Sub-Assurance #5:
Case managers are required to offer choice of providers, choice of waiver services and choice of institutional care to the participant and/or guardian at the time of the annual plan of care and six month review. The plan of care includes a section where the guardian and/or participant verify that they have reviewed their choices through a provider list,have reviewed the waiver services available, and they know they have a choice between home and community based services and the Wyoming Life Resource Center (the state ICF/MR). The DD Division tracks when and if choice was offered and discussed prior to or during the annual plan of care development meeting using the plan of care spreadsheet.
The state monitors this sub-assurance through participant and guardian interviews during the recertification process with providers and through participant National Core Indicator interviews. If it is discovered that the participant did not receive the opportunity to choose providers as requested or at a six month review or annual team meeting, the concern will result in a quality improvement plan by the provider to address this area of non-compliance.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant

direction.

ABI Waiver participants, who do not have a residential service on the waiver, are given the opportunity to receive:
1) Support services provided by qualified Home and Community Based Medicaid Waiver providers certified by the DD Division,
2) The option to self-direct their services, or
3) Both.

If self-directing one or more of their services, participants can act as the employer of record with the Fiscal/Employer Agent - Financial Management Service (FMS). This option gives participants the authority and responsibility to recruit, hire, schedule, evaluate and supervise their workers and gives the participant budgetary authority.

Participants can also choose to enter a co-employer arrangement with an Agency with Choice-FMS provider. This option gives participants the authority to recruit, schedule, evaluate, and supervise their workers. The Agency with Choice-FMS serves as the employer of record and has the final authority on hiring and firing workers. Participants using this model are the co-employer, and cannot terminate the worker from employment through the Agency with Choice-FMS, but can choose not to continue to receive services from the worker.

Participants choosing to be the employer of record and work with the Fiscal/Employer Agent-FMS may choose to have budgetary authority, however participants choosing to be a co-employer will not have the option to have budgetary authority.

In addition to receiving support from the Fiscal/Employer Agent-FMS, participants self-directing their services receive assistance as needed with the employer activities through the Support Broker, who is chosen by the participant. Support Brokerage is a required service for the first year a participant or representative self-directs services. After the first year, the participant may choose Support Brokerage services as needed. The DD Division has a process to allow participants to request to opt out of receiving Support Brokerage services based on specific criteria. Criteria includes participants self-directing through the Agency with Choice-FMS model, participants self-directing less than $5,000 of services, and participants who have successfully self-directed services for 1 year with no concerns. (Concerns include having compliance issues with fulfilling co-employer duties, utilizing services and budget inappropriately, having incidents that require more frequent monitoring from the case manager and/or the DD Division to ensure safety.) The DD Division may, however, require participants to receive Support Brokerage services if there are significant concerns with how the participant is self-directing services.

The DD Division has a self-direction handbook that provides information to participants on self-direction. DD Division staff review this handbook with applicants when they apply for the waiver, and the participant's case manager reviews this information when a funding letter is received so the participant or their representative can determine if they want to self-direct some or all of their services. The DD Division has basic training modules on self-direction, and participants or their legal representatives interested in self-directing services have the opportunity to attend a training in person or by viewing a DVD to review this information. DD Division staff located throughout the state serve as ongoing resources if questions or concerns arise about self-directing services.

If participants or their legal representatives choose to self-direct one or more services, they work with their case manager to choose a Support Broker in their geographic area who is certified by the DD Division, who can assist them with the self-direction process. Participants or their legal representatives can also choose to self-direct the Support Broker service as the common law employer and employ a Support Broker. This option is included to allow participants to choose a person well known to them who can provide Support Brokerage services but who does not meet the minimum requirements to be certified as a Support Broker provider through the DD Division. The person chosen by the participant can only serve as a Support Broker for that participant and must complete the same training as certified Support Brokers (described below).

Support Brokers are required to complete comprehensive training on self-direction and pass a competency based test. The training includes:

1) Principles of self-determination
2) What self-directing services means
3) The roles and responsibilities of the Support Broker, Financial Management Service - Fiscal/Employer Agent, the Financial Management Service - Agency with Choice, and the Case Manager
4) What the participant and Support Broker need to know about hiring and firing staff

The ABI Waiver includes the following services and supports to assist participants in self-direction:

1) A Financial Management Service provider serving as Fiscal/Employer Agent, which is funded as an administrative activity and does not come out of a participant's budget. The Fiscal/Employer Agent-FMS assures all Federal, state and local employment tax, labor and workers' compensation insurance rules and other requirements are followed when the participant functions as the employer of workers. The Fiscal/Employer Agent-FMS makes financial transactions on behalf of participants who have chosen to have budgetary authority.

2) Financial Management Service providers serving as Agency With Choice - a waiver service that allows participants choosing to self-direct to enter a co-employer agreement with an agency certified as a Medicaid Waiver provider, who withholds the appropriate taxes and other withholding, assures background checks and all other staff requirements are completed, training is completed, and assures the staff chosen by the participant is available at the times needed by the participant.

3) A Support Broker - a waiver service that assists a participant in self-directing services, including assisting them in finding staff, hiring and firing of staff while adhering to labor laws, managing the budget, reviewing and authorizing time sheets, and changing the plan of care when needed.

4) Case Management - a waiver service that develops and submits the plan of care to the DD Division, working with the participant self-directing and their Circle of Support, monitors the implementation of the plan of care, completes follow-up on concerns found with implementation of the plan.

All four of these services/supports have responsibility to provide protection and safeguards to participants self-directing services. The Fiscal/Employer Agent-FMS assures all IRS and other applicable employer requirements are met, assures workers chosen by participants meet all state requirements before services are provided, tracks budget utilization and purchases funded through Individualized Goods and Services to assure funds are being used appropriately, and reports concerns to case managers and the DD Division as required. The Agency with Choice-FMS provider assures workers chosen by participants meet all state requirements before services are provided, and monitors the services provided by the worker. The Support Broker assures the participant is following federal, state and local laws when hiring and firing staff, is monitoring the use of the budget and has planned for the entire plan year, and works with the participant and case manager when concerns arise. The Case Manager develops and monitors the implementation of the plan of care, including self-directed services, to assure health and welfare needs identified in the plan are met and risks are clearly identified and addressed.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☑ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The DD Division has a handbook that provides a simple summary of self-directing services. The handbook includes:

1) An overview of self-determination and self-directing services, including the principles of self-determination (Freedom, Authority, Support, Responsibility, and Confirmation).
2) The benefits of self-directing, including more choice and control over services and how the budget is spent.
3) The responsibilities involved in self-directing services, including hiring and firing workers, managing the budget, approving workers' timecards.
4) The potential liabilities of self-directing services, including liabilities that may occur as the common law employer when hiring or firing staff, managing the budget, and approving timecards.
5) Services/supports on the ABI Waiver that can assist them in self-directing, including the Support Broker, Financial Management Service provider serving as Fiscal/Employer Agent, Financial Management Service providers serving as Agencies with Choice, and Case Managers.
6) A basic assessment that will help the participant or their legal representative determine if self-directing is appropriate for them.
7) Further resources that may be helpful to participants who are considering whether or not to self-direct services, including local/state resources.

DD Division staff review the handbook with applicants who are applying for the ABI Waiver. When funding becomes available, the participant's case manager again review the handbook and discuss the options for self-directing services on the waiver.

For existing ABI Waiver participants, the case manager provides information on self-direction twice a year during home visits or team meetings, and at any time a participant expresses an interest in self-directing services.

In addition to the handbook, the DD Division has basic training modules on self-direction so participants or their legal representatives interested in self-directing services have the opportunity to attend a training in person or by viewing a DVD. DD Division staff located throughout the state serve as ongoing resources as questions or concerns arise about self-directing services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Companion Services	☑	☑
Community Integrated Employment	☑	☑
Supported Living	☑	☑
Personal Care	☑	☑
Unpaid Caregiver Training and Education	☐	☑
Respite	☑	☑
Individually-Directed Goods and Services	☐	☑
Independent Support Broker	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- (●) **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

  Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

  - [ ] **Governmental entities**
  - [x] **Private entities**

- ( ) **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- ( ) **FMS are covered as the waiver service specified in Appendix C1/C3**

  The waiver service entitled:

- (●) **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The DD Division released a request for proposal in July 2009 with the option to choose up to two vendors to provide Financial Management Services under a Fiscal/Employer Agent Model for the Division Waivers. Following Wyoming State procurement rules the bids were reviewed and scored based on a standardized tool. As a result of the review one vendor was chosen to provide Financial Management Services to people self-directing their services on the Division Waivers.

The DD Division is also offering a Agency with Choice - Financial Management Service option as a waiver service for people who choose to enter a co-employer arrangement with a local agency. The Agency with Choice FMS will not include budgetary authority.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The Fiscal/Employer Agent - Financial Management Service will be compensated by the DD Division for administrative activities based upon a per-member-per-month (PMPM) reimbursement method.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintains a separate account for each participant's participant-directed budget**
- [x] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [x] **Processes and pays invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

State Medicaid Agency and DD Division Policy for Monitoring the Fiscal/Employer Agent Financial Management Service:

The Vendor Fiscal/Employer Agent Financial Management Service shall be monitored to assure the Agent is adhering to Federal, State and DD Division regulations and standards.

The monitoring process shall include monthly monitoring by case managers, an annual review completed jointly by the DD Division and the Medicaid Program Integrity Unit, and ongoing monitoring through the DD Division’s complaint process and incident reporting process.

Policy Provisions:

The DD Division shall issue policy, procedure manuals, memorandums, instructions and other DD Division correspondence to interpret and implement the approved waivers, including information on the roles and responsibilities of the Fiscal/Employer Agent Financial Management Service, responsibilities of the case manager in the monthly monitoring of services provided by the Agent, and monitoring responsibilities of the DD Division and the Medicaid Program Integrity Unit.

The DD Division in conjunction with the Medicaid Program Integrity Unit shall complete an biennual review of the Fiscal/Employer Agent Financial Management Service for a representative sample of participants utilizing this service. The representative sample will have a confidence interval of 95% +/- 5% error rate.

The biennual review of the representative sample completed by the DD Division shall include a review of the following components:
• A review of participant files to verify the file has the following:
o A completed enrollment application for the participant that contains all required forms and information
o A federal employer identification number (FEIN) for the participant and copies of the participant's FEIN
o IRS FEIN notification and the filed Form SS-4, Application for Employer Identification Number in the participant's file
o A signed IRS Form 2678: Employer/Payer Appointment of Agent for the participant and documentation (copy of IRS Form 2678, Request for Approval Letter and IRS Notification of F/EA Approval) on file
o Written authorization from the IRS to be the Agent for the participant and a copy of the written authorization in the participant's file
o A copy of a current signed IRS Form 8821, Tax Information Authorization for the participant in the participant's file
o Obtained a state power of attorney (for state income tax, unemployment tax or both, as required by the state) from the participant it represents, maintained in the participant's file
• A review of participant workers' files to verify the file has the following:
o A completed employment packet for participant's employees that contain all required forms and information, including completed employment application, IRS Form W-4, state Form W-4, if applicable, (USCIS Form I-9, IRS Notice 797)
o Completed background checks, current CPR, current First Aid, and verification of required training
o Collected and processed an IRS Form W-4 from each worker it processes payroll and for maintaining a copy of the form in each worker's file
o Verification of worker's citizenship and alien status by collecting and maintaining a completed US CIS Form I-9, Employment Eligibility Verification for every worker it processes payroll for in each worker's file
o Verification of each worker's social security number and maintained the appropriate documentation in each worker's file
o Verification of the state of residence for each worker and maintained the appropriate documentation in each worker's file
o Having paid workers in compliance with federal and state Department of Labor wage and hour rules for regular and overtime pay
o Verification of and processing of workers' timesheets and copies maintained in the workers' files
o Documentation of the withholding of FICA (Medicare and social security taxes) and federal income tax for each worker per payroll period including the employer's contribution.

The biennial review of the representative sample completed by the Medicaid Program Integrity Unit shall include a review of the following components:
• A review of claims paid to the Fiscal/Employer Agent Financial Management Service for services received by participants in the representative sample, and corresponding paychecks paid to employees of the participants in the representative sample to assure the documentation supports the billing and payment for services
• A review of the timesheets and documentation of services to assure employees of participants are adhering to the current documentation standards for services
• A review of the per member per month payments to the Fiscal/Employer Agent Financial Management Service to assure payments are accurate

The DD Division shall monitor call center reports from the Agent quarterly. The reports shall be reviewed for timeliness of response, numbers of calls received, and other trends relating to call data.

The DD Division shall complete a review of the Agent's contract biennially or as needed if concerns arise.

The DD Division and the Medicaid Program Integrity Unit shall jointly complete a biennial review of the Fiscal/Employer Agent business practices to verify all required IRS regulations, as well as state unemployment

and worker's compensation regulations are being adhered.

The DD Division shall receive a copy of the Agent's independent audits annually.

The DD Division shall conduct customer satisfaction interviews with participants chosen in the representative sample. The interviews shall be conducted with both the common law employer (participant or their legal representative) and employees to assess the satisfaction of Fiscal/Employer Agent Financial Management Service, including timely processing of timesheets, timely resolution to customer service calls and assistance in completing enrollment packets.

The DD Division shall conduct an annual review of the Agent's complaint policy and complaints filed to ensure:
• Adequate written information is conveyed to the participant and or their legal representative, and to employees of the participant regarding how to file a formal complaint with the Fiscal/Employer Agent Financial Management Service.
• All complaints are reviewed in a timely manner and addressed appropriately to all parties concerned.
• Any complaints found that were not reviewed in a timely manner according to the Agent's policy or that were left unresolved will result in the Fiscal/Employer Agent Financial Management Service completing a Quality Improvement Plan, as specified in the Remediation section.

Procedures:

• The DD Division and the Medicaid Program Integrity Unit shall select the participants for the representative sample at the start of the state fiscal year, beginning July 1, 2011, and every two years thereafter. The representative sample of files to be reviewed shall have a 95% confidence interval and a +-5% margin of error rate and be selected by the DD Division. The review will be conducted over two years.
• The DD Division will maintain the findings of the file reviews and track the follow up of concerns identified through a database. If the Medicaid Program Integrity Unit identifies a concern with claims, the unit shall follow up as listed in the remediation section of this policy and report the status of an investigation or recovery with the DD Division. An annual report of the files reviewed the first year will be analyzed by the DD Division and the Medicaid Program Integrity Unit to track for trends or concerns. At the end of the two year cycle, a final report of the findings and follow up conducted during the two years will be compiled within sixty days of the end of the 2nd Fiscal Year. The report shall be distributed to the Fiscal/Employer Agent Financial Management Service, the DD Division Administration, and the Medicaid Program Integrity Unit.
• The DD Division and the Medicaid Program Integrity Unit shall review the participant and worker file reviews and Agent Review report with the Medicaid State Agent and any findings will be followed up in the process listed in the Remediation section of this policy.
• The DD Division shall conduct satisfaction interviews with participants and providers using the Agent's services and compile a report for review by Medicaid. Any concerns found will be followed up in the process listed in the Remediation section of this policy.
• The DD Division will review the Agent's business practices and complaint process to ensure the Agent is in compliance with DD Division rules, the Agent's contract, and the Agent's own written policies and business rules.

Remediation:

The Fiscal/Employer Agent Financial Management Service shall be required to address any concerns found within a specified time period designated by the DD Division, and, when applicable, to pay corresponding penalties and fees. These concerns would include the following:

• Missing documents in the participant file
• Missing documents in the participant's worker's file
• Problems with implementation or compliance with the Agent's contract
• Compliance or problems found with the Agent's business practices
• Issues noted in customer satisfaction interviews
• Unresolved complaints
• Unreported Incidents or flags on participants cases

The Agent's contract includes clauses for termination of the contract if serious concerns are identified.

The Fiscal/Employer Agent Financial Management Service shall submit a quality improvement plan within the requirements of Wyoming Medicaid Rules, Chapter 45 for each area of non-compliance identified in the

participant file review report within thirty days of receipt of the report.

The DD Division and the Medicaid Program Integrity Unit shall review and approve the quality improvement plan according to the Wyoming Medicaid Rules, Chapter 45 and shall monitor implementation of the quality improvement plan to assure areas of non-compliance are adequately addressed.

The Medicaid Program Integrity Unit shall complete the recovery of funds if documentation of services does not support the billing and payment for services.

The Medicaid Program Integrity unit shall complete the required process to assure the Centers of Medicare and Medicaid Services (CMS) is reimbursed for the federal portions of payments when recovery of funds occurs.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case managers provide initial information and assistance in support of participant direction when a participant receives a funding letter for the ABI Waiver, and twice a year or as needed for existing waiver participants through home visits or team meetings.

The information provided by the case manager includes a review of the handbook being developed by the DD Division, and a review of the Self-Direction self-assessment tool. The handbook includes:
1) An overview of self-determination and self-directing services, including the principles of self-determination (Freedom, Authority, Support, Responsibility, and Confirmation)
2) The benefits of self-directing, including more choice and control over services and how the budget is spent
3) The responsibilities involved in self-directing services, including hiring and firing workers, managing the budget, approving workers' timecards
4) The potential liabilities of self-directing services, including liabilities that may occur as the employer of record when hiring or firing staff, managing the budget, and approving timecards.
5) Services/supports on the ABI Waiver that can assist them in self-directing services, including the Support Broker, Financial Management Service - Fiscal/Employer Agent Provider, Case Manager, and Financial Management Service - Agency with Choice provider.
6) A basic assessment that will help the participant or their legal representative determine if self-directing is appropriate for them.
7) Further resources that may be helpful to participants who are considering whether or not to self-direct services, including local/state resources.

If a participant or their legal representative chooses to self-direct services, the case manager reviews the important role that the Support Broker has in assisting the participant in self-direction. The case manager provides the participant with a list of Support Brokers in their geographic area, and works with the participant, Support Broker, and Circle of Support to develop a plan of care that identifies non-waiver and waiver supports and services needed by the participant.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Specialized Equipment	☐
Occupational Therapy	☐
Prevocational Services - phased out Year 1	☐
Residential Habilitation	☐
Companion Services	☐
Community Integrated Employment	☐
Supported Living	☐
Day Habilitation	☐
Skilled Nursing	☐
Personal Care	☐
Environmental Modifications	☐
Unpaid Caregiver Training and Education	☐
Homemaker	☐
Respite	☐
Case Management	☑
Physical Therapy	☐
Speech Therapy	☐
Cognitive Retraining	☐
Individually-Directed Goods and Services	☐
Agency with Choice	☑
Dietician Services	☐
In Home Support - phased out Year 1	☐
Independent Support Broker	☑

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The Fiscal/Employer Agent-Financial Management Service provider gives information and assistance in support of participant direction specific to participants serving as employer of record. This assistance may be in the form of reviewing employer responsibilities with participants or their legal representatives, including accurate review of timecards, managing the budget and assuring workers submit required paperwork, both initially and ongoing.

The DD Division and the Program Integrity Unit of the Office of Healthcare Financing has processes for assessing the performance of the Fiscal/Employer Agent FMS. This process will include both auditing processes to assure the FMS is performing duties per IRS, federal, and state rules and regulations, satisfaction surveys of participants receiving FMS services from the vendor, and assessment of information and education provided by the FMS to participants.

Oversight of Vendor Fiscal Employer Agent Financial Management Service:
The state has developed a tiered approach to monitoring the performance of the Vendor Fiscal Employer Agent Financial Management Service, including oversight by the case manager, DD Division, and Medicaid's Program Integrity Unit.
The case manager reviews the performance of the Vendor Fiscal Employer Agent Financial Management service during the required monthly home visit with the participant. The case manager is required to document the specific concerns, complete and document follow-up actions to address the concerns, and assure the concerns are resolved. Follow-up includes, as appropriate:
• Direct contact with the Fiscal Employer Agent Financial Management Service informing them of concerns and working with them to resolve the issues.
• Meeting with appropriate parties involved, including the Support Broker, employee of participant who is involved in situation, and Vendor Fiscal Employer Agent Financial Management Service representative, to work through the concerns.
• Reporting issues to the DD Division if significant concerns are identified that impact health and safety, indicate

potentially fraudulent activity, and/or if concerns are not addressed by Vendor Fiscal Employer Agent Financial Management after the case manager has worked directly with them.

The DD Division monitors the Vendor Fiscal Employer Agent Financial Management Service through the following processes:
• Monitoring the Vendor Fiscal Employer Agent Financial Management monthly budget utilization reports for all participants self-directing services to assure reports are accurately reflecting service utilization, reviewing flagged participants who are over utilizing or under utilizing their budgets, and business rules are adhered to, including rules on service limitations.
• Completing an biennual review of Vendor Fiscal Employer Agent Financial Management Services for a representative sample of individuals utilizing this service. The representative sample will have a confidence interval of 95% +/- 5% error rate.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (•) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A participant may voluntarily terminate self-direction at anytime during their plan year. When a participant voluntarily terminates self-direction the participant works with the case manager who follows the DD Division transition process for changing services and/or service providers. Voluntary termination of self-direction does not

require that the participant change waivers, since traditional provider-based waiver services are available on the ABI Waiver as well as self-directed services.

The transition process includes a transition team meeting to assure the team, including all providers, have current information on the changes being made to the plan of care. During the transition team meeting the case manager revises the plan of care to reflect the changes in services and service providers. The plan of care is submitted to the DD Division for approval before the transitions occur. The DD Division has seven calendar days to review and approve the revised plan of care.

The case manager works with the participant or their legal representative to notify the appropriate Financial Management Service provider of the termination of self-directed services and assists the participant in completing any required paperwork.

The DD Division also has an emergency transition process in place if there are significant health and welfare concerns that may require a quicker transition out of self-directed services. This transition process requires that DD Division staff are involved in the transition process so the DD Division can assure the new services and service providers meet the needs of the participant and to assure the participant's health and welfare needs are met during the transition from self-direction. The case manager submits the revised plan of care to the DD Division, which can approve the revised plan within one business day if an emergency situation exists.

Once a participant has chosen to voluntarily terminate self-direction, they cannot choose to self-direct services until their six month or annual plan of care meeting, which will assure that the participant and team has an opportunity to plan the transition back to self-directed services carefully.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The situations that could result in involuntary termination are a part of the training guides, modules, and in trainings. The DD Division has processes in place to identify mismanagement of a budget, including budget oversight and reporting by the Financial Management Service, and review of monthly budget reports by the participant's Support Broker and Case Manager. The case manager is required to monitor the participant’s budget usage on a monthly basis. The Fiscal/Employer sends the Division an immediate notification if there is an advanced indication that the participant is over utilizing their budgeted amount. The case manager will also immediately report to the Division if a participant may be over utilizing their budgeted amount. A team meeting will be convened immediately to address the over utilization and assist the participant in making changes. The Participant, copied to Case Manager, is notified in writing by the Division if there are serious concerns about over utilization with a warning that if utilization is not corrected in the next quarter, the DD Division may pursue involuntary termination.

The DD Division can involuntarily terminate the use of participant direction when the following situations occur:

1) A participant or their representative is not managing the budget appropriately. The DD Division has processes in place to identify mismanagement of a budget, including budget oversight and reporting by the Financial Management Service, and review of monthly budget reports by the participant's Support Broker and Case Manager, as well as the DD Division. The DD Division will work with the participant's Case Manager, Support Broker, and the Financial Management Service - Fiscal/Employer Agent to provide additional training, education and support to help the participant understand their responsibilities with managing within the budget. However, if mismanagement of the budget continues the DD Division can involuntarily terminate the use of self-direction. The Support Broker is responsible for the day to day activities in dealing with employment, managing the participant’s budget, and adhering to labor laws. The Case Manager oversees, the long term of overall processes, which include developing and monitoring the plan of care. They are also required to monitor the Support Broker.

2) A participant's health and welfare needs are not adequately met. The DD Division has processes in place to identify when a participant's health and welfare needs are not adequately being met, including oversight by the participant's Case Manager and Support Broker, critical incident reporting, the complaint process, and oversight of self-directed services. The DD Division will work with the participant's Case Manager and Support Broker to provide additional

training, education and support to help the participant understand the need for the plan of care and for services to meet the health and welfare needs of the participant. However, if significant concerns with the participant's health and welfare continues, the DD Division can involuntarily terminate the use of self-direction.

3) The DD Division, the Office of Healthcare Financing, and/or the Medicaid Fraud Control Unit identify situations involving the commission of fraudulent or criminal activity associated with self-direction of services. When these situations occur the DD Division will work with the State Medicaid Agent, the Medicaid Fraud Control Unit and the Attorney General's office to identify the appropriate steps to take to remove the participant from participant direction of services pending the outcome of investigations.

Participants who are involuntarily terminated from self-directing are notified in writing of the involuntary termination and the reasons. The letter includes information on the right of the participant to request a Fair Hearing.

When a participant is involuntarily terminated from self-direction the participant works with the case manager who follows the DD Division transition process for changing services and/or service providers. Involuntary termination of self-direction does not require that the participant change waivers, since traditional provider-based waiver services are available on the ABI Waiver as well as self-directed services.

The transition process includes a transition team meeting to assure the team, including all providers, has current information on the changes being made to the plan of care. During the transition team meeting the case manager revises the plan of care to reflect the changes in services and service providers. The plan of care is submitted to the DD Division for approval before the transitions occur. The DD Division has seven calendar days to review and approve the revised plan of care.

The case manager works with the participant or their legal representative to notify the appropriate Financial Management Service provider of the termination of self-directed services and assists the participant in completing any required paperwork.

The DD Division also has an emergency transition process in place if there are significant health and welfare concerns that may require a quicker transition out of self-directed services. This transition process requires that DD Division staff are involved in the transition process so the DD Division can assure the new services and service providers meet the needs of the participant and to assure the participant's health and welfare needs are met during the transition from self-direction. The case manager submits the revised plan of care to the DD Division, which can approve the revised plan within one business day if an emergency situation exists.

Once a participant has been involuntarily terminated from self-direction, they cannot choose to self-direct services until their six-month or annual plan of care meeting, which will assure that the participant and team has an opportunity to plan the transition back to self-directed services carefully. In addition, the Division will work with the team to assure that safeguards have been put in place as necessary to assure the previous concerns or difficulties the participant had with self-directing services have been adequately addressed.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		0
Year 2		22
Year 3		22

Year 4 (renewal only)		22
Year 5 (renewal only)		22

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participants on the ABI Waiver may choose a co-employer arrangement that is supported by an agency that functions as the common law employer of workers recruited by the participant. The Agency with Choice-Financial Management Service (FMS) provider, provided as a waiver service, conducts all necessary payroll functions and is legally responsible for the employment-related functions and duties of participant-selected workers. The Agency with Choice-FMS provider has a written agreement with the participant outlining the roles, responsibilities and authority of each.

Providers certified by the DD Division to provide Agency with Choice-Financial Management Services share responsibility for the supervision and management of an employee with the participant. The Agency With Choice-FMS provider is responsible for employer responsibilities such as payroll, taxes, insurance, etc. The participant is responsible for selecting the worker, setting the worker's hours, and daily management of the worker's responsibilities. The Agency With Choice-FMS provider and the participant share responsibility for training and evaluation of worker performance, as outlined in the written agreement. The participant maintains the right to dismiss the worker from working with him/her. The agency maintains the right to determine whether the worker is dismissed from the agency.

Any vendor can apply to become an Agency of Choice-FMS through the DD Division's waiver provider certification process. Agencies need to demonstrate through policy, procedure and marketing materials that participants can choose the workers who provide services to them, can set the hours for the worker, can determine the tasks/activities the worker performs, can dismiss the worker from working with him/her and has a partnership role in the training and evaluation of the worker.

Participants' Support Brokers provide supports to assist participants in their responsibilities as managing employer.

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**

- [x] **Refer staff to agency for hiring (co-employer)**
- [x] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The costs of the criminal history check and Central Registry check are included in the per member per month fee paid to the Fiscal/Employer Agent-Financial Management Service.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The DD Division assigns budget amounts for each participant on the ABI Waiver as described in Appendix C-4 of this application. The budget limit does not change if a person chooses to self-direct services.

The process for determining a participant's individual budget limit, as described in C-4, is made available by request.

An Extraordinary Care Committee (ECC) database is maintained by the DD Division, which summarizes the decision of all requests, including if the decision and funding is time-limited. The ECC policy, procedure and forms for requesting additional funds are available on the DD Division's website for public viewing and use.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual budget limit is given to participants at the time funding is received for the waiver, before the plan of care is developed. Participants receive the same budget limit if they choose to self-direct services. Participants can submit requests through their case managers for an increase in the budget limit based on the plan of care development process.

If the participant's team identify that the budget allotted to a participant does not meet the services and supports needed in the developed plan of care, then the participant may request additional funding, subject to approval from the DD Division. Additional funding can be approved in two ways, either by the DD Division's Participant Support Manager or by the DD Division's Extraordinary Care Committee.

1) The DD Division may adjust the Individual Budget Amount for the following reasons:

- If a subsequent psychological assessment is required for continued waiver eligibility, or specialized equipment is needed and the cost may be added to the plan for ONE YEAR ONLY, not to exceed $1,000.
- If the participant has had a transition last plan year due to:
  - a change from school-funded services to waiver services
  - a substantial change in the person's health, safety, or service needs occurred
  - a delay in services on the plan due to a temporary lack of available service providers
- If the living situation changes to a less restrictive environment or if waiver services are reduced

• If significant changes in the participant's functioning occurs a revised individual budget amount, then the individual budget amount shall be based upon the median historical plan cost for like individuals based upon the service score taken from the Inventory for Client and Agency Planning (ICAP) assessment.

2) If the additional funding requested does not meet the above criteria or the Participant Support Manager requests a review from the DD Division's Extraordinary Care Committee (ECC), then the request will go to the ECC for review.

The ECC is the authorized entity to evaluate and approve requests for additional funding above a participant's individual budget. ECC requests are due to a health or safety emergency with participant, a material change in the participant's circumstances, or a potential emergency justifying an increase in funding. The Extraordinary Care Committee's membership includes the Participant Support Manager, the DD Division's Financial Manager, and a representative from the State Medicaid Agency. The committee reviews information compiled by the participant's case manager that details the reasons for the need for increased funding, including specific health and welfare needs that are not able to be adequately addressed within the individual budget amount.

The ECC can authorize:
1) A temporary increase in the individual budget amount for up to one year, or
2) A permanent increase in the individual budget amount.

Funding requests, which are modified or denied, are eligible for a fair hearing, and the participant is notified of this right.

The request must include specific information on the health, welfare, or service needs that cannot be met under the current budget limit, and this must be reflected in the plan of care developed by the participant's team.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**

◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The DD Division shall review and approve the participant's service plan annually. During the plan year, the DD Division will allow participants to modify services included in the participant's self-directed budget without prior DD Division approval as long as the participant is not increasing the overall individual budgeted amount. The participant shall coordinate modifications to the self-directed service budget with his/her case manager, who will submit the change to the Fiscal/Employer Agent FMS. The case manager shall assure the assessed needs of the participant can continue to be met, then update the plan of care to reflect the change in services and budget. The DD Division will monitor the modification process to the service plan and to the budget through the representative sample file review as explained in Appendix D.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The DD Division worked with the Vendor Fiscal/Employer Agent-Financial Management Service to establish safeguards for participant's budgets and to prevent the premature depletion of the budget or address potential service delivery problems that may be associated with budget over-utilization or under-utilization. The DD Division is responsible for ensuring the implementation of safeguards developed for the participants who are self-directing. The FMS vendor chosen by the DD Division has a web-based system that tracks budget utilization and provides monthly reporting to participants, case managers, support brokers and the DD Division.

The DD Division and the Vendor Fiscal/Employer Agent – Financial Management Service developed business rules within their web-based system that will flag participants for possible over-utilization. For example, if the participant's claims exceed more than 20% of the expected monthly utilization, the DD Division and the participant's case manager will automatically be notified through an electronic message. Likewise, the rules flag participants if two consecutive pay periods bear no claims or claims total 20% under expected utilization. If premature depletion of the budget or the lack of claims are noted by the FMS' web-based system, then the DD Division is automatically notified as well as the participant's case manager.

The DD Division shall follow up with the case manager to assure that the concern is addressed and resolved according to the DD Division's monitoring processes for case managers, which includes:

• Meeting with appropriate parties involved, including the Support Broker, employee of participant who is involved in situation, and Vendor Fiscal Employer Agent Financial Management Service representative, to work through the concerns.

• Reporting issues to the DD Division if significant concerns are identified that impact health and safety, indicate potentially fraudulent activity, and/or if concerns are not addressed by Vendor Fiscal Employer Agent Financial Management after the case manager has worked directly with them.

All follow up on issues reported to the DD Division will be documented and reviewed quarterly for trends or to determine if:
--participant education is needed
--provider re-education is needed, or
--further actions are needed by the DD Division and the FMS to prevent future occurences of the same problem.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals are notified and afforded the opportunity to request a Fair Hearing when the following occurs:
• An applicant does not meet the eligibility requirements for the waiver
• An applicant is not provided the choice of home and community-based services as an alternative to institutional care:
• A participant is denied the service(s) of their choice or the provider(s) of their choice

• A participant's services are denied, suspended, reduced or terminated
When any of these situations occur, the applicant or participant is notified in writing with specific information on how to request a Fair Hearing, in accordance with Wyoming Medicaid Rules, Chapter 34, Section 15 and Chapter 1, Section 9, including the time frames and procedures. The person is also informed that he/she may have an attorney, relative, friend, or other spokesperson represent them at the hearing if he/she chooses. The person has 30 days to request a fair hearing in writing to the Administrator of the Developmental Disabilities Division within the State Medicaid Agency. This information is also included in the Application Packet all applicants and guardians receive when applying for the ABI Waiver, and is explained by DD Division staff when reviewing the application process to the applicant or guardian.

If a participant is receiving waiver services, he/she is notified that services are not terminated or reduced pending the results of the Fair Hearing, unless otherwise authorized as specified in 42 CFR §431.230. This information is included in the letter sent to the participant or guardian.

Notices of adverse actions and the opportunity to request a fair hearing are kept on file at the DD Division for 6 years.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (○) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (○) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Wyoming Department of Health - Developmental Disabilities Division

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ABI Waiver participants, guardians, providers, and other interested parties can file complaints with the DD Division via the phone, letter, email, or on the web-based complaint system available on the DD Division's website. Complaints can be filed anonymously. All DD Division staff are responsible for receiving complaints and

entering complaints in IMPROV, the DD Division's provider management system. Complainants, who identify themselves, are sent a verification letter that the complaint has been received, next steps that will be taken, and the process of notifying them once the investigation is complete.

DD Division staff assesses the information in the complaint to determine if there is any suspicion of abuse, neglect, exploitation, intimidation or self-neglect, which by state law must be reported to the Protective Services unit of the Department of Family Services (DFS). In these cases, the DD Division completes the report the DFS and collaborates with DFS to determine the appropriate follow-up as described Section G-1 of this application.

If the DD Division staff believes there are significant health and welfare concerns with a participant, but the complaint does not identify suspected abuse, neglect, exploitation, intimidation, or self-neglect, then the staff is required to contact their Division manager and the Provider Support manager immediately to determine appropriate follow-up actions. These are classified as Level One Complaints. The managers coordinate the follow-up on Level One complaints to assure the immediate health and welfare issues are addressed and to oversee completion of the complaint investigation.

If the DD Division staff receiving the complaint does not identify significant health or welfare concerns, then they enter the complaint in IMPROV, which electronically adds the review of the complaint to the appropriate Provider Support staff's work queue for follow up. Provider Support staff review complaints entered into IMPROV within one business day to assign the priority level, the category of complaint, and to identify the appropriate investigation or follow-up actions that need to be completed. Below is more information on the priority level system in place to identify the time frame for investigating a complaint.

Level One complaints are those that indicate there are significant concerns with health, safety or rights and requires follow-up within one business day to assess and address the immediate health and safety concerns. The investigation must be completed within ten business days.

Level Two complaints are those that identify potential provider non-compliance that may be impacting the quality of services participant is receiving. The investigation must be completed within 30 days.

Level Three complaints indicate potential provider non-compliance that does not appear to be directly impacting the quality of services to the participant. Investigation must be completed within 90 days.

The final level is NAN – no action necessary. Complaint is either outside the scope of the DD Division and the complainant is notified of who may have authority to investigate or the complaint does not identify any compliance issues that can be investigated.

Complaints that involve waiver policies and procedures, waiver staff, or other specific waiver issues are referred to the appropriate DD Division Manager for investigation and/or follow-up. Complaints that involve provider non-compliance are referred to the appropriate DD Division staff for investigation. Complaints that identify concerns with the overall service system are reviewed by the DD Division’s management team and, when appropriate, the DD Division’s Advisory Council to determine if changes to rules, regulations, policies or procedures need to be made.

Action steps that may be taken to investigate a complaint include:
- On-site investigation, including interviews with participant(s),staff and guardian/family members and review of provider documentation
- Requesting copies of documentation/records
- Contacting providers, staff, participants or guardians/family by telephone to gather information

DD Division staff update IMPROV on the results of any complaint investigation, and notify the provider whether the complaint has been substantiated, which requires the provider to submit a quality improvement plan to address the area(s) of non-compliance. The complainant is also notified of the results of the investigation following HIPAA and confidentiality laws within 7 days of the results of the investigation.

If the complaint is substantiated DD Division staff track the submission and approval of the quality improvement plan through IMPROV to assure the area of non-compliance is adequately addressed.

The DD Division’s complaint process is not a prerequisite or substitution for a Fair Hearing. If complaints are received that relate to situations where a Fair Hearing can be requested, the complainant is reminded of their right to request a Fair Hearing, and the complaint process does not replace that right or delay the time lines to request a Fair Hearing. The requirements for the DD Division's compliant process are found in Wyoming Medicaid Rules, Chapter 45, Section 30.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Per the Wyoming Adult Protective Services Act (WS 35-20-103): “Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited, intimidated, abandoned or is committing self neglect, shall report the information immediately…”

Per Wyoming Medicaid Rules, Chapter 45, Waiver Provider Certification and Sanctions, Section 30, all ABI Waiver providers and provider staff are required to report incidents to the DD Division, the Wyoming Department of Family Services - Protective Services Unit, Protection & Advocacy Systems Inc., the case manager, the guardian as required by law, and to law enforcement if a crime may have been committed. Reports must be filed immediately after assuring the health and safety of the participant and other individuals, and include the following categories:

Suspected abuse, including intimidation
Suspected neglect
Suspected self-neglect
Suspected self-abuse
Suspected abandonment
Suspected exploitation
Police involvement
Injuries caused by restraints, including drugs used as restraints, physical restraints, and mechanical restraints
Serious injury to the participant
Death
Elopement

In addition to the categories above, all ABI providers and provider staff are required to report medication errors and emergency restraint usage to the DD Division only, using the web based incident reporting system, unless the medication error is a result of suspected abuse, neglect or other reportable category listed above. In these cases the incident must also be reported to the Wyoming Department of Family Services - Protective Services Unit (DFS), Protection & Advocacy Systems Inc., the case manager, the guardian as required by law, and to law enforcement if a crime may have been committed.

Providers filing incident reports must file them through the DD Division's web-based system or faxed to the DD Division using the standardized "Notification of Incident" form. Participants, guardians, and families may contact the DD Division to report an incident, although they are also encouraged to report directly to the Department of Family Services Protective Services unit so DFS can gather pertinent information for their investigation. If the participant, guardian or family does not want to contact DFS, the DD Division will file the report with DFS on their behalf.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation,

including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The DD Division, with the help of a working group of stakeholders, developed a booklet concerning protections from abuse, neglect, and exploitation, including how participants and/or families or guardians can notify appropriate authorities when the participant may have experienced abuse, neglect or exploitation. This booklet is provided to participants, families/guardians by DD Division staff at the initial acceptance of services and at DD Division staffattended
team meetings. DD Division explains the contents of the booklet and answer questions the participant or family/guardian may have concerning these issues. The booklet is available to any one attending state DD Division related conferences. The booklet is also posted on the DD Division website. Case Managers are encouraged to review this information with participants on their caseload during home visits. For people self-directing services, the chosen Support Broker trains participants, their legal representatives, other members of the Circle of Support, and workers hired by participants on abuse, neglect and exploitation. This training includes how to notify appropriate authorities when abuse, neglect or exploitation is suspected.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Per Wyoming Medicaid Rules, Chapter 45, Section 29, ABI Waiver providers, provider staff, and workers employed by participants self-directing services are required to report incidents to the DD Division, the Wyoming Department of Family Services - Protective Services Unit, Protection & Advocacy Systems Inc., the case manager, the guardian as required by law, and to law enforcement if a crime may have been committed. Reports must be filed immediately after assuring the health and welfare of the participant and other individuals. If a potential crime has been committed law enforcement is involved and, when appropriate, works directly with the Wyoming Department of Family Services Protective Services Unit to coordinate investigations. If criminal charges are filed against a ABI Waiver provider or worker employed by a participant self-directing services, the DD Division immediately suspends the provider pending the outcome of the criminal case. If the provider is convicted, they are immediately decertified as provider or terminated as a worker of a self-directing participant. If criminal charges are filed against provider staff, the provider is required to immediately remove the staff from providing direct care services pending the outcome of the criminal case.

DFS investigates suspected abuse, neglect, exploitation, self-neglect or abandonment and has an intake and referral process when incidents are reported. DFS has the statutory authority to substantiate cases, resulting in a person being listed on the Abuse Central Registry and informs the DD Division when a substantiation occurs involving a ABI Waiver provider, provider staff or worker employed by a self-directing participant. Per Chapter 45, providers appearing on the Central Registry are immediately suspended from providing services and decertified within 60 days unless they submit a new Central Registry Screening verifying they are not listed on the registry. The 60 day delay in decertification is required so the provider can appeal the DFS decision before being decertified as a provider.

Protection and Advocacy, Systems Inc. (P & A) has federal authority under the Developmental Disabilities Assistance and Bill of Rights (DD) Act of 1975 and is required by the Act to pursue legal, administrative and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under all applicable federal and state laws. As part of this authority, P & A receives and reviews all critical incident reports involving ABI Waiver providers and participants, including participants self-directing services. P & A has a separate intake and investigation process for incidents, but does collaborate with the DD Division when there are concerns with the health and welfare of participants and/or when P & A identifies potential non-compliance with rules and regulations by an ABI Waiver provider, provider staff or worker employed by a self-directing participant.

Once a critical incident has been filed, P & A is notified by the provider immediately so that they can conduct their own investigation of the incident. P & A reviews the incident and then gives formal notice that they will be investigating the incident. This can entail interviewing the provider, provider staff involved, provider staff that were not involved but were witness to the incident, and the participant and/or guardian. Once their investigation is complete, P & A provides formal written notification to the Division, provider, and participant and/or guardian when concerns are found that impact the health and welfare of the participant. This contact entails full notification of P & A's findings to all of the above, as well as, recommendations for the state on what they feel the DD Division should look into and the reasons why. They also give recommendations to the participant and/or guardian on what specific rights they have when concerns have been substantiated.

The DD Division investigates incidents and, when appropriate, substantiates provider non-compliance with Medicaid

rules and regulations, including concerns with participants' health and welfare. If through follow up on incident reports a provider is found to be non-compliant with rules, regulations or policies it is required to submit a quality improvement plan that identifies the area of non-compliance, the action steps to be taken by the provider to address the non-compliance, the timeframe for addressing each action step, and the responsible party for each action step.

Quality Improvement plans are due to the DD Division within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The participant, guardian and, when appropriate the case manager are notified by letter of the non-compliance if it directly relates to the participant receiving services, adhering to HIPAA and confidentiality laws.

The DD Division's incident intake process is separate from the Department of Family Service's process. Incident reports are submitted by providers and other stakeholders through a web-based system. The DD Division has access to the incident database via IMPROV, the DD Division's web based provider management system, and are required to check for incidents throughout the day, with the requirement that they review incidents within one business day. The DDD Provider Support Manager or designee reviews the status of reported incidents in IMPROV to assure incidents are reviewed within this timeframe.

Upon receipt of an incident that identifies suspected abuse, neglect, exploitation, self-neglect or abandonment, DD Division staff contact the Wyoming Department of Family Services (DFS), Protective Services Unit to determine if DFS is going to open a case or if there is police involvement. If there is police involvement, or if DFS determines a reported incident is within their statutory authority to investigate, the DD Division cannot complete follow-up on the specific incident until the investigations are completed.

The DD Division does complete immediate follow-up with the provider if there is a potential that the participant involved in the incident and/or other participants are at risk due to the provider's non-compliance with rules, regulations and policies. These are classified as Level One Incidents. The DD Division notifies DFS follow-up is going to be completed and the results of the investigation are shared with DFS as appropriate. If participants continue to be at significant risk the DD Division requires the provider to immediately alleviate the risks, can remove the participants if the risks are not alleviated, and can sanction the provider. The DD Division uses a priority level system to identify the appropriate follow-up to be taken. Below is a summary of the levels:
Level One – Highest Consideration: Person's health or safety appears to be at immediate risk and provider compliance needs to be ensured. This requires follow-up actions by the DD Division within 1 business day.
Level Two – Medium Consideration: Person's health or safety is of significant concern and provider compliance needs to be ensured. This requires follow-up actions by the DD Division within two weeks.
Level Three – Lower Consideration: Although no substantial health and safety concerns, the incident may impact the care of the person and provider compliance needs to be ensured. This requires follow-up actions by the DD Division within 2 weeks-1 month.
NAN – No Action Necessary: Adequate information and follow up have been provided. No concerns with health/safety and no compliance must be ensured.

The DD Division must review and approve the provider's quality improvement plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the quality improvement plan may include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

All pertinent information on the review and follow-up completed on incident reports is maintained in IMPROV, the DD Division's provider management system, including the status of quality improvement plans. Information on sanctioned providers is also maintained in IMPROV.

The DD Division timeframes for reporting results to participants/guardians are based upon the level assigned to the incident. Level 1- 30 days, Level 2 – 60 days, and Level 3 – 90 days. Participants/guardians are notified in writing the results of the DD Division's investigation into an incident.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Family Services, Protective Services unit (DFS) is responsible for overseeing and responding to critical incidents that identify suspected abuse, neglect, exploitation, self-neglect, intimidation or abandonment. DFS has the authority to pursue criminal charges per Wyoming State Statute 35-20-111, which states, "any person or agency who knows or has sufficient knowledge which a prudent and cautious man in similar circumstances would have to believe that a vulnerable adult is being or has been abused, neglected, exploited, intimidated or abandoned, or is committing self neglect, and knowingly fails to report in accordance with this act is guilty of a misdemeanor

punishable by imprisonment for not more than one (1) year, a fine of not more than one thousand dollars ($1,000.00), or both." When an Adult DD Waiver provider, provider staff, or worker employed by a self-directing participant delays in reporting an incident, they are required to explain the reason for the delay in the incident report being filed. DFS reviews this information to determine if the provider knowingly failed to report the incident, and determines if further action is needed by DFS. The DD Division, per Wyoming Medicaid Rules, Chapter 45, requires a provider reporting late incidents to submit a quality improvement plan addressing the non-compliance. If participants continue to be at significant risk the DD Division requires the provider to immediately alleviate the risks, can remove participants if the risks are not alleviated, and can sanction the provider.

The DD Division conducts monitoring activities to assure providers are reporting incidents as required. These activities include:

Provider certification process – Providers must be recertified at least every two years. Part of the recertification process includes assessment of providers and provider staff knowledge of reportable incidents to assure they are aware of the categories of reportable incidents and how to report. All providers are required to have an incident reporting policy that includes the requirements in the DD Division's Notification of Incident process and this policy is reviewed during each provider recertification.

Incident Reporting Process – providers are required to report critical incidents to the appropriate authorities immediately after assuring the health and welfare of the participant. The DD Division reviews each incident report to assure that it was reported within the required timeframe to the appropriate entities. The DD Division does follow-up to assure that the provider has responded appropriately to the incident and is taking appropriate action to assure the health and welfare of participants and to minimize risk. When appropriate the DD Division also completes follow-up on incidents during provider recertifications as a double check to assure that the follow-up has been completed and to assess how the participant is doing.

The DD Division timeframes for reporting results to participants/guardians are based upon the level assigned to the incident. Level 1- 30 days, Level 2 – 60 days, and Level 3 – 90 days. Participants/guardians are notified in writing the results of the DD Division's investigation into an incident.

Training process for workers employed by participants self-directing services - Workers employed by participants self-directing services are required to receive training on recognizing and reporting abuse, neglect, intimidation, self-neglect, exploitation and abandonment, as well as training on the DD Division's notification of incident process. This training is initially provided by the participant's Support Broker, and must be reviewed annually.

Complaint process – The DD Division's complaint process can and has identified situations where a reportable incident occurred but was not reported as required. When this occurs, the DD Division requires that the provider report the incident and also requires that they submit a quality improvement plan to address their failure to report incidents.

Representative Sample review process - The DD Division reviews a representative sample of ABI Waiver participants to assess the effectiveness of the implementation of plans of care. Included in this process is a review of incident reports and other participant specific documentation to assure incidents are reported accurately and within the timeframe required by the DD Division, appropriate follow-up is completed on incidents by the case manager and provider(s), and the plan of care is updated when appropriate based on the follow-up completed.

If a provider is found to be non-compliant with rules, regulations or policies it is required to submit a quality improvement plan that identifies the area of non-compliance, the action steps to be taken by the provider to address the non-compliance, the timeframe for addressing each action step, and the responsible party for each action step. Quality Improvement plans are due to the DD Division within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The DD Division must review and approve the quality improvement plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the quality improvement plan may include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

All pertinent information on the review and follow-up completed on incident reports is maintained in IMPROV, the DD Division's Provider Management system. Recommendations and quality improvement plans are tracked through IMPROV as well, including verification the quality improvement plan has been implemented appropriately. In addition to completing follow-up on individual incidents the DD Division reviews data on incidents on a quarterly basis to identify significant trends and to determine appropriate actions to take to prevent the recurrence of incidents. Actions taken may include retraining of participants, ABI Waiver providers, and provider staff on

recognizing and reporting abuse and neglect, exploitation and self-neglect, distributing information to participants, guardians, and providers on causes of serious injuries that can be avoided, such as assuring participants have proper footwear in the winter to avoid falls, working with a specific provider who has an increase in incidents identifying specific concerns with services, and/or completing participant and provider training on any other specific trend identified in the data. The goal is to minimize the occurrences and recurrences of incidents.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Safeguards for restraint usage are written into Wyoming State Statute 35-1-625 and 626, which mandate participants must be free from physical restraints and isolation except for emergency situations or when isolation or restraint is a part of a treatment program; and isolation or restraint of a participant may be used only when less restrictive measures are ineffective or not feasible for the welfare of the participant and shall be used for the shortest time possible.

The DD Division has specific safeguards in place concerning use of restraints in Wyoming Medicaid Rules, Chapter 45, which prohibits the use of seclusion in home and community based waiver services. In Chapter 45, Section 27, restraints are defined as:

• Drugs used as a restraint: Any drug that is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others, and has the temporary effect of restricting the participant's freedom of movement, and is not a standard treatment for the participant's medical or psychiatric condition.

• Mechanical restraints: Any device attached or adjacent to a participant's body that he or she cannot easily move or remove that restricts freedom of movement or normal access to the body.

• Personal restraints: The application of physical force or physical presence without the use of any device, for the purposes of restraining the free movement of the body of the participant. The term personal restraint does not include briefly holding, without undue force, a participant in order to calm or comfort him or her, or holding a participant's hand to safely escort him or her from one area to another.

• Emergency restraints: A restraint used in an emergency due to significant concerns with the health and welfare of the participant or others, which is not authorized in the participant's plan of care.

Any restraint usage, must be ordered by a physician or qualified behavioral health practitioner, written in the participant's plan of care, and reviewed and approved by the participant, guardian, and the DD Division. Least restrictive measures must be attempted first, and when restraint usage is identified in the plan of care, a positive behavior support plan must be developed that focuses on positive interventions. Providers are required to document that the participant has been consulted regarding alternatives he or she

prefers prior to the development of the behavior support plan that includes the use of restraint, when possible.

All providers are required to have policies on restraint usage, including a policy on whether they will use emergency restraints, such as a personal restraint, as a time-limited emergency measure until the appropriate law enforcement, safety or other emergency service providers arrive on site. When an emergency restraint occurs, providers are required to notify the guardian and case manager so the case manager can convene a team meeting to assess the use of the emergency restraint and to work with the participant and team on identifying appropriate changes to the plan of care. These changes may include authorization of restraint usage, but the team is encouraged to consider less intrusive methods if appropriate.

Providers are required to document the use of restraints as an incident following the provider's internal incident reporting policy. Restraint usage must be reported to the DD Division when an injury results from the use of restraints. Providers are required to notify the DD Division, through the incident reporting process, of use of emergency restraints. The DD Division will complete follow-up monitoring to assure the team meets and the plan of care is revised appropriately.

All rights restrictions in the plan of care, including restraint usage, have to identify the following:
1) Why the restriction is imposed
2) How it is imposed
3) A plan to restore rights
4) A date to review restrictions

Providers using restraints must assure less restrictive intervention techniques are used prior to the use of restraint, assure the individual plan of care includes limitations or specific descriptions of the proper restraint to use or not use on the participant, and identify the designated provider staff to provide face-to-face evaluation of the participant within one hour of the use of restraint to assure there are no injuries or other concerns and to assure the provider staff are following the participant's plan of care and restraint standards, including using the least restrictive approach first.

Providers are required to obtain and maintain restraint training from entities that are certified to conduct such training before agreeing to provider services for any participant who has restraint use in the plan of care. Staff involved in the direct administration of restraints must also receive initial and annual competency-based training in the following:
1) The contributing factors or causes of threatening behavior.
2) The use of alternative interventions, such as mediation, de-escalation, self-protection, and time out, which still permits the participant the freedom to leave the time-out area
3) Recognizing signs of physical distress in the person who is being restrained.
4) The re-establishment of communication after a person has been restrained.
5) The prevention of threatening behaviors
6) When and how to restrain safely

Removal from restraint must occur as soon as the threat of harm has been safety minimized. Restraint cannot be used as coercion, discipline, convenience, or retaliation by staff.

Analysis of restraint usage occurs on the participant level, provider level and at the state level as described below:
1. Providers are required to review and discuss each use of restraint. The participant, the guardian and staff are included in the discussion, which should address:
• The incident.
• Its antecedents.
• The reasons for the use of restraint.
• The person's reaction to the intervention.
• Actions that could make future use of restraint unnecessary.
When applicable, modifications should be made to plan of care to address issues or behaviors that impact the need to use restraint.

2. The chief executive or designated management staff member is required to review and sign off on all uses of restraint after every occurrence. The review must include:
• Verification that the provider's policies and procedures regarding restraints were followed
• Verification that the behavior support plan for the participant was followed

• Determination if modifications to the treatment plan are needed
• Determination if staff involved in the restraint had received appropriate training and utilized this training appropriately when using a restraint
• Verification that recommendations identified during the review of the restraint usage are appropriate and are being implemented

3. Case managers are required to complete an analysis of restraint usage monthly for each participant to identify trends and to work with the team to make appropriate changes to the plan of care as needed. Data on restraint usage shall be submitted to the DD Division quarterly. The state requires in rule that providers who use restraints have internal systems in place to follow up on restraint and restriction usage and remediate their processes as necessary. If a restraint results in a critical incident, providers have to report it to the DD Division as a critical incident and will warrant involvement from the DD Division according to the state's criteria specified in Appendix G-1.

Waiver certified case managers are responsible for ensuring a participant's safeguards by keeping accurate up-to-date records regarding a participant's restraint usage and restrictive interventions identified in their positive behavior support plans. Case managers are given this information through an internal incident report provided by the direct care staff or their supervisor after a restraint has occurred and when a restrictive intervention has taken place. Case managers review this information on a regular basis to analyze any trends and report this information to the Division on a quarterly basis.

4. The use of restraint must be recorded in the provider's information system and reviewed for:
• Analysis of patterns of use
• History of use by personnel
• Environmental contributing factors
• Assessment of program design contributing factors

If the frequency of use of restraint, including physical restraint, mechanical restraint, and chemical restraint changes, the chief executive or a designee must investigate the pattern of use and take action to continuously reduce or eliminate the use of restraint.

5. The DD Division oversees the use of restraints or seclusion and ensures that State safeguards concerning their use are followed as described in G-2-a-ii.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The DD Division monitors compliance with restraint rules through the plan of care approval process, provider recertification process, representative sample process, incident-reporting process, complaint process and Extraordinary Care Committee review process. The focus of this monitoring is to assure restraint usage is only occurring when necessary as a last resort, is authorized as required in state rules, is approved in the plan of care, and to assure staff have appropriate training in both restraint usage and in de-escalation techniques and other non-evasive approaches to working with participants.

Plan of Care Approval Process
DD Division staff review and approve each plan annually. This review includes a review of authorized restraints written in the plan of care to assure the restraint is ordered by a physician or qualified behavioral health practitioner, has been approved by the guardian and participant, that least restrictive measures were attempted first, and a positive behavior support plan is included in the plan of care that focuses on positive interventions. The review also includes assuring seclusion is not listed in the plan as a restriction.

Provider Recertification Process
Providers are certified for a period of up to two years. The recertification process includes monitoring the use of restraints to ensure that state requirements are being followed and to detect unauthorized, inappropriate or ineffective use of restraints and use of seclusion. This monitoring includes:
• A review of provider/provider staff files to verify the provider has current training from an entity certified to conduct the training, such as MANDT or CPI.
• Interviews with providers and provider staff about restraint usage to assure restraints are only used when absolutely necessary and it is written into the participant's plan of care, and to verify seclusion is not being used.
• A review of the provider's information system and results of the analysis of restraint use to assure trends

are being identified and areas of concern are addressed at the provider level.
• Workers of participants self-directing services will be required to meet the same standards as all providers and provider staff.
• A review of each provider's policies and procedures on restraint usage and on emergency restraints, including verification the policy states seclusion will not be used.

Representative Sample Review
• The DD Division will complete a review of the implementation of plans of care, including a review of restraint and restrictive intervention usage and tracking, for a representative sample of ABI Waiver participants, including participants self-directing services. The representative sample will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of the implementation of the plans of care will be completed throughout two fiscal years.

Included in this review will be:
• A review of case management documentation of ABI Waiver participants, including participants self-directing services, for a six month period to verify the case manager is consistently monitoring use of restraints and restrictive interventions, including completing follow-up when concerns are found and updating the plan as needed.
• A review of a representative sample of ABI Waiver participant files to assess the documentation of restraint usage, including the documentation of the review and discussion required after each use of restraints. This includes a review of case management documentation for the random sample of ABI Waiver participants to verify the case manager has completed the monthly evaluation and trend analysis of restraint usage and has completed appropriate follow-up on concerns.

Incident and Complaint Processes
When restraint usage is reported through incidents or complaints the DD Division reviews the participant's plan of care to assure that restraint usage is authorized and that a positive behavior support plan is in place and was followed. Incidents and complaints are reviewed to verify seclusion is not being used.

Extraordinary Care Committee Review Process:
When the DD Division's Extraordinary Care Committee approves an increase in a participant's budget, DD Division staff complete follow-up as appropriate to verify the funding is being utilized appropriately and the need for the additional funding still exists. This review may include a review of participant specific documentation, including documentation of restraints and restrictive interventions used, to assure rules and standards are being followed.
The unauthorized or inappropriate use of restraints and the use of seclusion can be uncovered through any of the processes listed above. If the unauthorized use of restraints is found, the provider is required to immediately put safeguards in place to assure there are no more restraints used until the team is able to evaluate the reason for the unauthorized restraint and to identify appropriate follow up actions. If the use of seclusion is found, the provider is notified to immediately stop the practice and the DD Division completes an on-site investigation to assure seclusion is not being used. Per Wyoming Medicaid rules, Chapter 45, the Office of Healthcare Financing - State Medicaid Agency completes a recovery of funds for the services provided at the time seclusion was used.

If a provider is found to be non-compliant with rules, regulations or policies, including the unauthorized use of restraints, it is required to submit a quality improvement plan that identifies the area of noncompliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step. Quality Improvement plans are due to the DD Division within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The DD Division must review and approve the quality improvement plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the quality improvement plan may include an onsite visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

The DD Division is in the process of developing a web-based electronic plan of care, which will allow case managers to report information on restraint and restrictive intervention usage by participant on an ongoing basis. The anticipated completion date for the web-based electronic plan of care is Fall 2010. Until that system is in place, case managers are required to submit information on restraint and restrictive intervention usage to the DD Division for each participant on their caseload by fax or email on a quarterly basis. The information is entered into a database for tracking and analysis purposes, described below.

In addition to monitoring restraint and restrictive intervention data on the participant and provider level, the DD Division reviews aggregate data quarterly to identify systemic trends in this area that may need addressing before the annual review of data and information as outlined in the Quality Improvement Strategy section of this application (Section H.) Examples of how trends may be addressed by the DD Division include, enhancing training in this area, releasing a bulletin clarifying a standard or rule, and/or revising the plan of care approval process to assure restraint or restrictive interventions are appropriately approved during the plan review. The goal is to assure restraint and restrictive interventions are only used when necessary and per rules and standards.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The DD Division has specific safeguards in place concerning use of restrictive measures in Wyoming Medicaid Rules, Chapter 45.

Restrictive interventions include:
• limits on a participant's movement
• limits on a participant's access to other individuals, locations or activities
• the use of other aversive techniques (not including restraint or seclusion) that are designed to modify the participant's behavior.

Restrictive interventions must be included in the plan of care and reviewed and approved by the participant, guardian and the DD Division. The plan of care must also include a plan to restore rights and periodic reviews of the restrictions. The DD Division has specific safeguards in place concerning use of restrictive interventions, which include least restrictive measures must be attempted first; and, when restrictive interventions are identified in the plan of care, a positive behavior support plan must be developed that focuses on positive interventions. Providers are required to document that the participant has been consulted regarding alternatives he or she prefers prior to the development of the behavior support plan that includes the use of restrictive interventions, when the participant can express preferences.

All rights restrictions in the plan of care, including restrictive interventions, have to identify the following:

1) Why the restriction is imposed
2) How it is imposed
3) A plan to restore rights
4) A date to review restrictions

Providers and provider staff are required to receive participant specific training, including training on rights restrictions and restrictive interventions.

Providers are required to document the use of restrictive interventions as an incident following the provider's internal incident reporting policy.

Analysis of use of restrictive interventions occurs on the participant level, provider level and at the state level as described below:
1. Providers are required to document each use of restrictive interventions and to review the use of the restrictive intervention to assure it was authorized in the participant's plan of care and implemented appropriately
2. Case managers are required to complete an analysis of restrictive interventions monthly for each participant to identify trends and to work with the team to make appropriate changes to the plan of care as needed.
3. The DD Division oversees the use of restrictive interventions and ensures that State safeguards concerning their use are followed as described in G-2-b-ii.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The DD Division monitors compliance with restrictive interventions through the plan of care approval process, provider recertification process, incident-reporting process, and complaint process. The focus of this monitoring is to assure restrictive interventions occur only when necessary as a last resort, are authorized as required in state rules, are approved in the plans of care, and to assure staff have appropriate training in approved restrictive interventions for each participant.

Plan of Care Approval Process:
DD Division staff review and approve each plan annually. This review includes a review of restrictive interventions written in the plan of care to assure the restrictive intervention has been approved by the guardian and participant, least restrictive measures were attempted first, and a positive behavior support plan is included in the plan of care that focuses on positive interventions.

Provider Recertification Process:
ABI Waiver providers are certified for up to two years. The provider recertification process includes monitoring the use of restrictive interventions to ensure that state requirements are being followed and to detect unauthorized, inappropriate or ineffective use of restrictive interventions. This monitoring includes:

• Review of provider/provider staff files to verify the provider has current training on restrictive interventions written into each participant's plan of care.
* Interviews with providers and provider staff about use of restrictive interventions to assure they are only used when necessary and are written into the participant's plan of care.
• Review of the provider's information system and results of the analysis of restrictive intervention use to assure trends are being identified and areas of concern are addressed at the provider level
• Review of a representative sample of ABI Waiver participant files to assess the documentation of use of restrictive interventions. The representative sample size will have a 95% confidence level and a margin of error of 5%. This includes a review of case management documentation for the random sample of ABI Waiver participants to verify the case manager has completed the monthly evaluation and trend analysis of use of restrictive interventions and has completed appropriate follow-up on concerns.

Incident and Complaint Processes:
When use of restrictive interventions is reported through incidents or complaints the DD Division reviews the participant's plan of care to assure that the use of restrictive interventions authorized and that a positive behavior support plan is in place and was followed.

The unauthorized or inappropriate use of restrictive interventions can be uncovered through any of the processes listed above. When this occurs the provider is required to immediately put safeguards in place to assure there are no more restrictive interventions used until the team is able to evaluate the reason for the unauthorized restrictive intervention and to identify appropriate follow up actions.

If a provider is non-compliant with rules, regulations or policies, including the unauthorized use of restrictive interventions, it is required to submit a quality improvement plan that identifies the area of

non-compliance, the action steps to be taken by the provider to address the non-compliance, the time frame for addressing each action step, and the responsible party for each action step. Quality Improvement plans are due to the DD Division within 15 business days if the recommendation identifies concerns with health, safety or participant rights and within 30 calendar days for all other concerns. The DD Division must review and approve the quality improvement plan, and monitor implementation of the plan. The type of monitoring completed on the implementation of the quality improvement plan may include an on-site visit, request for documentation, follow-up interviews with participants, provider and/or provider staff, or follow-up during the next provider recertification.

The DD Division is developing a web-based electronic plan of care, which will allow case managers to report information on restraint and restrictive intervention usage by participant on an ongoing basis. The anticipated completion date for the web-based electronic plan of care is Fall 2010. Until that system is in place, case managers are required to submit information on restraint and restrictive intervention usage to the DD Division for each participant on their caseload by fax or email on a quarterly basis. The information is entered into a database for tracking and analysis purposes, described below.

In addition to monitoring restraint and restrictive intervention data on the participant and provider level, the DD Division reviews aggregate data quarterly to identify systemic trends in this area that may need addressing before the annual review of data and information as outlined in the Quality Improvement Strategy section of this application (Appendix H.) Examples of how trends may be addressed by the DD Division include, enhancing training in this area, releasing a bulletin clarifying a standard or rule, and/or revising the plan of care approval process to assure restraint or restrictive interventions are appropriately approved during the plan review. The goal is to assure restraint and restrictive interventions are only used when necessary and per rules and standards.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

First line monitoring: The participant's physician, psychiatrist, or other licensed medical professional who prescribes medications to the participant shall be the first line monitor of the participant's medication regimen. The first line monitor shall be accessed by the participant, guardian, case manager and designated team member(s) to conduct regular assessments of medication regimens, side effects, or when concerns arise regarding a participant's treatment plan, health condition or potentially harmful contraindicated medications are used.

Second line monitoring: Medication regimens shall have a second line of monitoring conducted by the participant's case manager, in conjunction with designated members of the participant's team. Case Managers shall monitor medication regimens by:
1) Ensuring all medications, medical treatments, and medication assistance are described accurately and fully in the plan of care and updated as needed.
2) Ensuring providers receive training on the participant's plan of care.
3) Conducting reviews of events as defined in the state's medication assistance policy.
4) Ensuring professional medical assessments are performed at least annually, or as needed by responsible

parties, to include:
a) Medication reviews to prevent the concurrent use of contraindicated medications
b) Blood tests and liver function tests to monitor the effects of psychotropic or seizure medications on one's body
c) Any follow up medical visits needed to monitor the participant's health post-injury, post-surgery, or after any significant change in treatment plan
5) Documenting review of the participant's health, medical condition, medication regimen, incident reports, PRN usage, and pertinent health risks at least quarterly on the case management quarterly form, or as deemed appropriate for the participant by the participant's medical professional. At least quarterly, or as health or safety risks arise, the case manager must monitor the participant for significant health changes, including:
a) Significant changes in weight (either weight gain or loss)
b) Increase in seizure activity or changes in type or duration of seizures
c) Unplanned changes in diet and/or food intake
d) Changes in adaptive equipment needs or in condition of equipment
e) Significant changes in type or frequency of behaviors
f) Changes in medication
g) Use of PRN medications
h) Any other significant health changes
i) Follow up actions taken on Incident Reports, PRN usage, or other identified health risks or concerns

Monitoring of PRN usage:
A qualified person, in accordance with state standards, who a provider deems responsible for analyzing the patterns of PRN usage, will work in conjunction with the participant's case manager to assure an appropriately trained medical professional continually assesses, monitors, and re-evaluates the participant to determine if the PRN medication is still needed or is still appropriate for the participant's medical condition.

The frequency of the monitoring, which shall be done at least quarterly by the case manager but may be needed more frequently for some participants or types of medication.

Monitoring Behavioral Modifying Medication:
First line monitoring of behavioral modifying medication shall be the responsibility of the participant's physician, psychiatrist, or other licensed medical professional who prescribes medications to the participant. The first line monitor shall be accessed by the participant, guardian, case manager and designated team member(s) to conduct regular assessments of medication regimens, side effects, or when concerns arise regarding a participant's treatment plan, health condition or potentially harmful contraindicated medications are used.

Second line monitoring of behavioral modifying medication shall be conducted by the participant's case manager, in conjunction with designated members of the participant's team.

When a medication is given for the purposes of modifying a behavior, including prescribed medications and non-prescription sedating medications, the provider shall have policy and procedures for assisting and monitoring medication in compliance with the state's standards. The policy and procedures shall include:
1) The qualified person(s) responsible for assisting the participant with medications.
2) The qualified person on the participant's team who will be designated to assure an appropriately trained medical professional continually assesses, monitors, and re-evaluates the participant to determine if the behavioral modification medication is still needed, is having adverse effects on the participant, or is still appropriate for the participant's medical condition.
3) How the medication will be used in accordance with the type, frequency, duration, route, and specific instructions as prescribed by the participant's licensed medical professional involved in his/her treatment plan.
4) Specific PRN instructions for behavioral modifying medication, including:
a) Documentation of the PRN as an internal incident report
b) The qualified person evaluating the participant face-to-face within one hour after the PRN is taken and documenting the participant's reaction to the PRN.
c) The types of incidents relating to PRN usage or administration that would be deemed "critical incidents" and reportable to the Division, DFS, Protection & Advocacy Systems Inc, the participant's case manager and guardian, if applicable.
d) The responsible person for reviewing the use of the PRN medication for behavioral modification purposes.
e) The requirements of the review, including:
i) Verification that the provider's policies and procedures regarding medication assistance and the participant's PRN protocols in the plan of care were followed.
ii) Verification that the positive behavior support plan for the participant was followed, including less

restrictive techniques.
iii) Determination if modifications to the treatment plan or medication regimen are needed or should be requested to the participant's medical professional.
iv) Determination if staff involved in the use and administration of the PRN had received appropriate training in accordance with the Division standards and utilized this training appropriately when assisting with the PRN medication.
f) Recording the review of each PRN used in the provider's information system and reviewed for:
i) Analysis of patterns of use.
ii) History of use by personnel.
iii) Environmental contributing factors.
iv) Assessment of program design contributing factors.
5) If PRN usage is suspicious or raises concerns regarding the participant's health and safety, then the provider shall investigate the pattern of use and take action to continuously reduce or eliminate the PRN usage, change medications, or otherwise address the medication regimen under the direction of the participant's licensed medical professional.
6) Any concerns or incidents that qualify as a critical incident according to the Division's state requirements shall be filed with the DD Division as described in Appendix G-1-d.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

To ensure appropriate medication management by providers, all providers assisting participants with medication regimens must comply with the state requirements for medication assistance, including:
1) The development and implementation of internal medication assistance policies and procedures that meet the Division's standards.
a) Through implementation of the provider's policies and procedures, the provider ensures:
i) Only prescribed medication, or medications specified through consent of the participant or guardian and deemed appropriate by the participant's medical professional, shall be included in the participant's medication regimen.
ii) Only qualified persons, as dictated by Division's standards, assist a participant with medications.
iii) The participant receives consistent and appropriate assistance with the medication as described by the prescription and instructions from the participant's medical professional.
2) The participant, or guardian if applicable, gives consent to allow a provider to assist with the participant's medication.
3) Only qualified persons, which is a licensed medical professional or a state Approved Medication Assistant, assist a participant with medication. To become an Approved Medication Assistant, the provider or provider staff must complete the required training.
4) The participant's case manager, in conjunction with designated member(s) of the participant's team, oversees the ongoing monitoring of the participant's medication regimen as described in the plan of care.
5) The assistance needed by the participant is accurately reflected in the plan of care, including any other special instructions or participant education needed for assisting with the medication, and providers must be trained on the participant's plan of care.

The DD Division is responsible for overseeing and monitoring provider compliance with the Division's medication assistance policy and standards, potentially harmful practices and the provider's own policies and procedures.

The DD Division oversees provider compliance with state standards and requirements through the Area Resource Specialists attending team meetings, the Survey/Certification unit completing recertifications, waiver specialists approving each plan of care, and as needed through follow up to critical incidents reported. Through these regular channels of communication and monitoring, the State ensures that participant medications are managed appropriately and monitors for potentially harmful practices.

The case manager and all providers are responsible for reporting unsafe practices to the DD Division through the critical incident reporting process and reporting critical medication errors to the DD Division. Through critical incident reports, complaints, provider certification or recertification processes, the Division completes follow up on any identified health or safety concerns regarding medication assistance. During follow up of a medication assistance concern the Division may review the provider's:
1) Medication assistance policies and procedures
2) Medication error policies and procedures

3) Medication-related forms, including
a) Incident Reports
b) Medication Assistance Records (MARs)
c) Medication Error forms
d) Medication and/or PRN reviews
e) Case management documentation of follow up

If the Division identifies health or safety concerns regarding medication assistance, such as unsafe practices or non-compliance with the Division's standards and requirements, then the provider must:
i) Rectify the situation as quickly as possible, subject to approval by the Division
ii) Receive re-education on the Division's standards, policy and procedures on Medication Assistance,
iii) Train or retrain personnel as needed to safely assist participant's with medication, and
iv) Address the areas of non-compliance before the next recertification is completed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Policy: The Division ensures participant medications are managed and monitored in accordance with the State's standards by requiring all home and community-based waiver providers, who assist participants with medications, to develop and implement policies and procedures in accordance to the standards listed herein.

STANDARDS
Providers assisting participants with medication regimens must comply with the state requirements for medication assistance as listed in this policy.
1) The participant or guardian must give consent to allow a specific provider or providers to be recognized as "friends" in accordance with the Wyoming Nursing Practice Act, Title 22, Chapter 21, 33-21-154, (iii) which allows for "the incidental health care by members of the family and friends." This allows the DD Division to get medical consent from participants and families to permit providers to assist with medications.

2) During waiver services, only qualified persons can assist a participant with medication. Qualified persons include licensed medical professionals who can administer medications within the scope of the medical licensure, or Medication Assistants who completed and passed the state approved curriculum and competency based test. Retraining is required at least every two (2) years.

3) If a Medication Assistant has a medication error, the DD Division will review the error to possibly require retraining contingent upon the findings of the investigation.
i) Retraining includes an overview of the original curriculum, observation of medication assistance tasks by a medication assistant trainer or licensed medical professional and satisfactory completion of a competency-based test approved by the Division.

4) The participant's case manager, in conjunction with designated member(s) of the participant's team, oversees the ongoing monitoring of the participant's medication regimen as described in the plan of care.

5) The assistance needed by the participant must be accurately reflected in the plan of care, including any

other special instructions or participant education needed for assisting with the medication.

6) The provider must comply with the Division's standards for medication assistance and the provider's own internal medication assistance policies and procedures, which cover:
i) Medication Consent
ii) Qualified Persons to assist with medications
iii) PRN protocol
iv) Behavioral Modifying Medications
v) Medication Storage and Labeling
vi) Medication Records
vii) Medication Assistance Records
viii) Medications Off-site
ix) Medication Error Reporting

7) The policies and procedures must also include verification that:

i) Only prescribed medication, or medications specified through consent of the participant or guardian and deemed appropriate by the participant's medical professional, are included in the participant's medication regimen.
ii) Only qualified persons assist a participant with medications.
iii) The participant receives consistent and appropriate assistance with the medication as prescribed by the participant's medical professional.

8) The Division oversees provider medication management and assistance and potentially harmful practices by monitoring providers' compliance with these standards through critical incident reports, complaint follow-up, certification and recertifications, or as the need of a participant arises. Requirements of State monitoring is detailed in Appendix G-3-c-iv of this application.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Developmental Disabilities Division

(b) Specify the types of medication errors that providers are required to *record:*

All providers are required to develop policies and procedures to comply with the following DD Division standards for recording, reporting and tracking medication errors. Medication errors that providers are required to record include:
i) Wrong medication
ii) Wrong dosage
iii)Missed medications
iv) Wrong participant
v) Wrong route
vi) Wrong time – Deviation from accepted standard time frame for the medication assistance
(1) Standard Medication Assistance Time frame is one hour before or after the scheduled time of medication assistance or as prescribed due to special circumstances, i.e. mealtimes.

Also, providers have additional medication errors or incidents that are reportable within their organization, but
not reportable to the DD Division. These categories include:
i) Refusals,
ii) Dropped medication,
iii) Expired or damaged medication,
iv) Other medication events determined to need action

(c) Specify the types of medication errors that providers must *report* to the State:

Medication errors reportable to the DD Division include any occurrence of the following:
* Wrong medication
* Wrong dosage
* Missed medication
* Wrong participant
* Wrong route
* Wrong Time – Deviation from accepted standard time frame for the medication assistance (Standard Medication Assistance Time frame is one hour before or after the scheduled time of medication assistance or as prescribed due to special circumstances, i.e. mealtimes).

Medication Errors reported to the DD Division do not have to be reported to Protection & Advocacy Systems, Inc., Department of Family Services, or police unless a crime has been committed, such as medication diversion or other misuse of medication. The DD Division will review the medication error and determine if the incident must be reviewed by other investigative parties for further follow up.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Responsible entity:
The DD Division is responsible for monitoring the performance of ABI Waiver providers who assist participants with medications. Monitoring occurs through regular contact with providers. DD Division staff attending team meetings monitor the medication regimen being written in the plan and follow up that is discussed with team members. DD Division staff review and approve each plan of care to assure the participant's assessed needs and medical information align with the medication and medical treatment outlined in the plan. The Survey/Certification unit of the Division completes participant file reviews and various participant and staff interviews during certification and recertification processes, and conducts investigations and follow up for critical incidents or complaints reported to the Division's critical incident reporting system, managed in IMPROV. Through these regular channels of communication and monitoring, the State ensures that participant medications are managed appropriately and monitored for potentially harmful practices.

How monitoring is performed:
Monitoring compliance with the state standards occurs during regular contact with providers, such as team meetings, site surveys during recertifications, plan of care review, and incident report or complaint follow up.

Medication errors reported through the DD Division's critical incident reporting system are tracked through the IMPROV database daily by DD Division staff. If a medication error is reported through a critical incident report, the DD Division will investigate the incident to ensure the necessary follow up is conducted to rectify the situation and prevent further occurrences. Follow up may include requiring re-training for the provider or provider employee associated with the medication error. In these cases, the provider will have to pass the competency based test for medication assistance with 100% accuracy before continuing to assist with medications.

When any member of the DD Division notices a problem with a provider's medication assistance practices, an internal referral is made through the Division's provider management system, IMPROV. Survey/Certification staff within the Division are responsible for completing follow up as needed on the referral. Examples of problematic medication assistance are any medication error, misuse of a participant's medication, or unsafe practices that are not in compliance with the state standards. IMPROV tracks the details of the referral and the follow up actions taken by DD Division Survey/Certification staff to remediate the problem with the provider. If changes are made to medications or treatment plans as a result of the meeting or follow up medical appointments, then changes to the plan of care are made by the case manager and distributed to team members.

Follow up requirements vary depending upon the concern identified, but the monitoring may include a review

of the provider's:
1) Medication assistance policies and procedures
2) Medication error policies and procedures
3) Medication-related forms, including
   a) Incident Reports
   b) Medication Assistance Records (MARs)
   c) Medication Error forms
   d) Medication and/or PRN reviews
4) Case management documentation of follow up

If the Division identifies health or safety concerns regarding medication assistance, such as unsafe practices or non-compliance with the Division's standards and requirements, then the provider must:
1) Rectify the situation as quickly as possible, subject to approval by the Division
2) Receive re-education on the Division's standards, policy and procedures on Medication Assistance,
3) Train or retrain personnel as needed to safely assist participant's with medication, and
4) Address the areas of non-compliance within the timeline specified by the Division and always before the next recertification is completed.

Frequency of Monitoring:
The DD Division monitors provider compliance in various frequencies depending on the type of monitoring. Monitoring will occur at team meetings attended by DD Division staff, but frequency depends on staff availability for attendance. Monitoring occurs annually through annual review of the plan of care by waiver specialists at the DD Division. The DD Division also monitors provider compliance with medication management at least every two years, depending on provider recertification dates. During the certification/recertification process, a statistically valid sample of the number of the waiver participants served at the time of monitoring will be used. Secondly, the ratio of those needing medication assistance to the total sample will be used to estimate the universe of those requiring medication assistance. Then a statistical sample of participants requiring med assist will be reviewed. The records reviewed are listed in the next paragraph.

The DD Division is responsible for monitoring provider compliance with the DD Division's medication assistance policy and standards. The DD Division reviews a sample of 1) provider personnel files to ensure qualified persons are assisting participants with medications and 2) provider's participant files who receive medication assistance. Sampling and process described below.

1) The DD Division maintains a registry for all providers and provider personnel who have completed the Medication Assistance curriculum requirements. During an initial certification or a recertification of a provider, which occurs at least every two years, the DD Division reviews the provider's training records for persons who are Medication Assistants. A statistically valid sample of Medication Assistant personnel employed by a provider are reviewed based upon the number of persons trained for that provider according to the DD Division's registry.

2) The DD Division will also review a representative sample waiver participant files will be reviewed to verify if the participant is receiving the monitoring, medication management, and assistance with medication in a healthy and safe manner according to the State standards. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of the implementation of the plans of care will be completed throughout two fiscal years.
• In addition to the DD Division's review of implementation of plans of care described above, the Division will also review a sample of case management documentation of ABI participants for a six month period to verify the case manager is consistently monitoring medication assistance, including completing follow-up when concerns are found and updating the plan as needed. The representative sample size will have a 95% confidence level and a margin of error of 5%. The sample will be identified in July of each year and the review of the implementation of the plans of care will be completed throughout two fiscal years.

The results of this monitoring activities will be maintained in IMPROV, the DD Division's provider management system, to identify trends and make changes as needed in this area. Changes could include enhancing the training modules for Medication Assistants, increasing monitoring activities to assure compliance with the standards, and/or releasing general bulletins in specific areas to remind providers of the standards.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of critical incidents to ABI participants, by type of incident and substantiated or unsubstantiated (the number of incidents of each type substantiated and unsubstantiated divided by the total number of reported critical incidents)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI participants injured while being restraints (the number of ABI participants injured while being restrained divided by the total number of ABI participants with restraint usage written in plan of care)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ABI Waiver Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of medication errors by type (the number of each type of medication error divided by the total number of medication errors for ABI participants.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medication errors reported to the DD Division are entered and tracked in the DD Division's provider management system called IMPROV.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

☑ **Continuously and Ongoing**	☐ **Other** Specify:
☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of ABI participants interviewed who report they feel safe in their home, neighborhood, workplace and day program (the number of participants interviewed who affirm they feel safe in these areas divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☑ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

Contractor for National Core Indicators		
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: aggregation of data occurs over two year period but a report is generated annually

Performance Measure:
Proportion of ABI participants interviewed who report having someone to go to for help when they feel afraid (the number of participants interviewed who affirm in response to this question divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: aggregation of data occurs over two

	year period but a report is generated annually

Performance Measure:
Proportion of ABI participants interviewed who report they are receiving preventative medical services by category (the number of participants reporting yes in each category divided by the number of participants interviewed)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☑ **Other** Specify: Contractor for National Core Indicators	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Interviews are completed over a two year period to obtain a representative sample. A preliminary report is compiled in the first year so significant trends can be identified.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute aggregates the data and generates a preliminary report and a final report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: aggregation of data occurs over two year period but a report is generated annually

Performance Measure:
Number of deaths of ABI participants by category of death (the number of deaths by category divided by the number of deaths of ABI participants)

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Methods of Discovery - Health and Welfare:

Critical incidents are sent to the DD Division via the Division's website. These incidents are automatically recorded in the Division's provider management system, IMPROV. All providers are also required to send a copy of the critical incident to the guardian, case manager, DFS, and Protection and Advocacy. Division staff are responsible for assigning a category for the incident depending on the severity and what it entails. DFS and Protection and Advocacy review all critical incidents that are filed and complete full investigations when it is suspected that abuse, neglect, or exploitation might have occurred, or when restriction of rights might have been violated.

Providers are also required to report to the Division any restraint that results in an injury using the same website. Injuries that are a result of a restraint must also be reported to DFS, Protection and Advocacy, the guardian, and the case manager. If a restraint is used on a participant that does not result in an injury, it still must be reported to the Division at the same website; however, this does not need to be reported to DFS or Protection and Advocacy. This includes any emergency restraints that are used on a participant. Division staff are responsible for reviewing all restraint usage to ensure provider compliance.

Medication errors must be reported to the Division so that the Division can provide the required re-training to providers. These errors need to be reported to the Division at the same website but do not need to be reported to DFS or Protection and Advocacy unless they meet the category of a critical incident. Division staff are responsible for reviewing all instances of medication errors for provider compliance.

When Division staff identify individual problems concerning health, safety and rights are discovered through an incident report or complaint, providers receive a "recommendation" from the Division. A recommendation identifies the specific area of non-compliance and providers are required to submit a quality improvement plan within a specified time frame to address the area of non-compliance. All recommendations and any follow up completed by the Division are documented in the Division's provider management system, IMPROV. The quality improvement plan must include specific action steps, responsible parties, and time frames for completing each action step. The quality improvement plan template is on the DD Division's website at http://health.wyo.gov/ddd/ddd/carfpiforms.html and providers can go to the website if they need assistance

with writing a quality improvement plan, or they can contact the Division for more clarification and guidance. The quality improvement plan must be submitted to the DD Division within 15 business days if the recommendation identified concerns with health, safety or rights, and within 30 calendar days otherwise. The DD Division must review and approve the quality improvement plan for each recommendation. The DD Division must also monitor the implementation of the quality improvement plan to assure the area of non-compliance has been addressed. This monitoring may include on-site visits, review of documentation, and interviews with providers, provider staff, participants, guardians and/or case managers. The type of monitoring completed depends on the type of non-compliance and severity of the situation. In addition, all recommendations are reviewed by the Division during the provider's next recertification to assure the area of non-compliance continues to be addressed.

If a provider fails to submit an acceptable quality improvement plan after several attempts working with the DD Division, the DD Division can impose a sanction. Sanctions include suspending admissions, suspending the provider, decertifying the provider, requiring additional training, imposing civil monetary penalties, and/or imposing a monitor within the provider organization.

When providers receive a recommendation, which can occur through the recertification process, complaint process, or incident reporting process, the information is entered into the DD Division's provider management system (IMPROV). IMPROV is a web based system that automatically tracks the category of recommendation, due date for the provider to submit the quality improvement plan for each recommendation, and the status of the recommendation. IMPROV includes letters/information sent to the provider identifying the area of non-compliance and the results of the review of the quality improvement plan. Overdue quality improvement plans are listed as "overdue" in a work queue that both the Survey/Certification Unit and Survey/Certification Manager have access. This process assures the DD Division is able to track the status of all quality improvement plans.

The Survey/Certification Manager reviews the status of quality improvement plans on a weekly basis, and completes a quality assurance check within IMPROV to assure staff have entered the information on the quality improvement plan into IMPROV, have sent the appropriate notifications, have reviewed the submitted quality improvement plans, and are monitoring the implementation of the plan.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The DD Division within the State Medicaid Agency has 10 major processes that provide information or data on how the six major waiver assurances are being met. These processes include:
1. Waiver Applicant Process: Level of Care. Data collected in Waiver Application Referral Database.
2. Attendance at Team Meetings: Level of Care, Service Plan, Qualified Providers, Health and Welfare, Financial
Accountability. Data collected in Team Meeting Database.
3. Plan of Care Approval: Level of Care, Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in Waiver Plan of Care Database.
4. Extraordinary Care Review: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in Extraordinary Care Committee Database.
5. Provider Recertification: Service Plan, Qualified Providers, Health and Welfare, Administrative Authority, Financial Accountability. Data collected in IMPROV.
6. Complaint Process: Service Plan, Qualified Providers, Healthand Welfare, Financial Accountability. Data collected in IMPROV.
7. Incident Reporting: Service Plan,
Qualified Providers, Health and Welfare, Financial Accountability. Data collected in IMPROV.
8. Satisfaction Surveys: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data

collected in Participant Case Review Database
9. Mortality Review: Service Plan, Qualified Providers, Health and Welfare, Administrative Authority, Financial Accountability. Data collected in Mortality Review
Database.
10. Representative Sample process: Service Plan, Qualified Providers, Health and Welfare, Financial Accountability. Data collected in Participant Case Review Database.

Data collected from these processes are compiled and reviewed quarterly by the DD Division's management team, the Medicaid Waiver Programs Coordinator, and the Medicaid Program Integrity Manager to identify significant trends that need to
be addressed before the annual trend analysis is completed on each performance measure. Data from the most recent quarter for each performance measure will be compared to data from the two previous quarters. When significant trends are found that require follow-up actions, the DD Division's management team works with the State Medicaid Agent to identify the appropriate steps to take to address the gap in a timely manner, the responsible party for completing the follow-up, and the performance measures to be tracked to verify the trend has been addressed appropriately. This information is shared with the DD Advisory Council, and the DD Division reports the results of the steps taken to the Advisory Council to assure the gap has been addressed.

A formal analysis of the data for each of the six assurances is completed annually within three months after the close of the waiver year. Results of the trend analysis, including strengths and areas needing improvement, are compiled into a report and presented to both the State Medicaid Agent and the DD Advisory Council within six months after the close of the waiver year. The DD Advisory Council consists of representatives from the following: • Governor's Planning Council for People with Developmental Disabilities • Wyoming Protection & Advocacy Systems, Inc. • Regional Service Providers • Family members/participants from the waivers administered by the DD Division• Self-employed case manager • Wyoming INstitute for Disabilities • Wyoming Department of Education

The Council provides recommendations to the DD Division based on the results of the review. These recommendations may include: • A change in rule, policy and/or procedure to address the gap • Forming a working group to further analyze the data and recommend changes •
Developing/enhancing training in specific areas • Other recommendations to identify a specific gap The DD Division along with the State Medicaid Agent has final authority on what recommendations are implemented.

System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: DD Advisory Council	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

System design changes may be identified during the quarterly review of the performance measures or during the annual trend analysis completed in conjunction with the DD Division's Advisory Council, both described in Section H-1-a. Once system design changes have been agreed upon, the DD Division with the State Medicaid Agent identifies the following:
• Who will oversee the systems change, which depends on the assurances impacted by the change
o The State Medicaid Agent or designee will take the lead on the changes impacting Administrative Authority and/or Financial Accountability
o The DD Division will take the lead on changes impacting Level of Care, Service Plan, Qualified Providers, and Health and Welfare
• Identification of other agencies or stakeholders who should be involved in system design changes
• Major action steps to implement the change
• The timeline for the change, including time lines for each major action step
• Identification of performance measures and appropriate data collection to track the results of the systems change
• Timeline for assessing impact of change
The DD Division, the Office of Medicaid Waiver Liaison, and the Medicaid Program Integrity Manager review implementation of systems changes quarterly to review process on the system changes, to identify potential barriers, and to make changes as needed to the action plan to implement system changes. The DD Advisory Council is updated semi-annually on the implementation of the system improvements through a written report and formal presentation.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The DD Division presents information on the effectiveness of the quality improvement strategy, including the effectiveness of the performance measures, processes used by the DD Division to gather data, changes to databases or data analysis, and issues with data reliability, annually to the DD Division's Advisory Council. The DDD Advisory Council makes recommendations on changes to the quality improvement system, and the DD Division works with the State Medicaid Agent to identify appropriate changes based on these recommendations. A timeline is developed to implement changes that includes responsible parties, action steps, and deadlines for each major step. The DD Division's Advisory Council is updated on the progress of the changes, and the changes are reported to CMS in an annual report.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for

waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) As stated in Wyoming Medicaid Rules, Chapter 45, Adult DD Waiver providers who are required to obtain CARF accreditation must have an anuual independent financial audit. The audit is submitted to the State Medicaid Agency each year.

(b) The method used by the financial audit program is claim research and includes three types of review: MMIS claims review, EFADS, and provider documentation. MMIS claims review includes the review of provider eligibility, c;ient eligibility, procedure code billed, and rate paid. The EFADS review include peer-to-peer review, ad hoc reporting, and approximately 30 standard claim filters which report quarterly on such items as claims paid after date of death and waiver claims paid during an impatient stay. Provider documentation review includes review of required provider documentation for submitted claims.

The scope is a sample of all DD Adult Waiver claims.

The frequency is quarterly.

The DD Division, in conjunction with the Medicaid Program Integrity Unit, developed a process for monitoring the Financial Management Service Fiscal/Employer Agent and the Agency with Choice FMS providers, including a process to audit claims submitted by the agent, as outlined in Appendix E.

(c) Wyoming Medicaid Rules, Chapter 3 (Provider Participation), Chapter 16 (Program Integrity), and Chapter 39 (Excess Payments)

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of ABI waiver claims paid for services not included in the service plan. (number of ABI waiver claims paid for services not included in the service plan divided by number of ABI waiver claims paid)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of ABI Waiver claims paid at the correct rate. (number of ABI Waiver claims paid at the correct rate divided by the number of ABI Waiver claims paid)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of ABI Waiver claims paid to a provider enrolled, in good standing, and entitled to receive payment. (Number of ABI Waiver claims paid to a provider enrolled, in good standing, and entitled to receive payment divided by number of ABI Waiver claims paid).

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The DD Division's re-certification process and complaint process can identify billing errors or potential fraud, as can routine investigative techniques used by the Medicaid Program Integrity Unit. Referrals can be made from the DD Division to the Medicaid Program Integrity Unit or Medicaid Fraud Control Unit for investigation. The status of recoveries and investigations are discussed at monthly CURT (Core Utilization Review Team) meetings held by the Medicaid Program Integrity Unit.

As part of its representative sample review of claims paid to providers, the Medicaid Program Integrity unit will review the claims paid to the Vendor Fiscal Employer Agent Financial Management Service and supporting documentation to verify that the documentation supports the billing and payment for services. If discrepancies are found the Vendor Fiscal Employer Agent will be required to pay back the funds.

The DD Division and Medicaid Program Integrity Unit will jointly complete an annual review of the Vendor Fiscal Employer Agent business practices to verify all required IRS regulations, as well as state unemployment and worker's compensation regulations. The DD Division will request a copy of independent audits conducted by the vendor.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If the identified problem is related to service plans or prior authorization, the DD Division would investigate how the error occurrred and correct it. If the error involved the part of prior authorization that is done by the MMIS Contractor, the MMIS Contract Manager would be included in the resolution. The Division would also investigate if the problem was an isolated incident or had occurred more than once, which might indicate the need for a system change. Any claims paid in error would be recovered.

If the identified problem related to rates, the DD Division would investigate how the error occurred and correct it. If the error involved something that is done by the MMIS Contractor, the MMIS Contract Manager would be involved in the resolution. The Division would also investigate if the problem was an isolated incident or had occurred more than once, which might indicate the need for a system change. Any claims paid in error would be recovered.

If the identified problem was related to provider certification, the DD Division would investigate how the error occurred and correct it. If the error involved the part of provider enrollment that is done by the MMIS contractor, the MMIS Contract Manager would be involved in the resolution. The Division would also investigate if the problem was an isolated incident or had occurred more than once, which might indicate the need for a system change. Any claims paid in error would be recovered.

In general, when a problem with a claim is identified by the DD Division, they may offer additional education or refer the care to the Medicaid Program Integrity Unit or Medicaid Fraud Control Unit for possible recovery of funds and/or investigation for fraud. If preliminary investigation by the Medicaid Program Integrity Unit shows that the concern was unintentional on the part of the provider, provider education is given. Provider education needed due to poor documentation is done by the DD Division. Provider education needed due to a billing problem is done by the Program Integrity Unit and/or the Provider Relations section of the MMIS contractor. Additionally, if provider documentation is found to be inadequate, funds paid to the provider are recovered by the Medicaid Program Integrity Unit. If preliminary investigation by the Medicaid Program Integrity Unit raises suspicion of fraud or abuse by a provider, the Program Integrity Manager refers the case to the Medicaid Fraud and Control Unit for further investigation. Recoveries and investigations will be tracked through E-FADS, an enhancement to the Program Integrity Unit's tracking system.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

In 2008 the DD Division within the State Medicaid Agency was required by state statute (W.S. 42-4-120 (g)) to establish by rule and regulation a cost based reimbursement system to pay providers of services and supplies under home and community based waiver programs for persons with developmental disabilities or acquired brain injury.

The DD Division established the following objectives in its rate determination:
• Rate standardization and equity – Rates are standardized, and based on the reported costs of providing services. Rates are consistent for similar services, regardless of which provider is providing the service.
• Reflect participant needs – the rates provide sufficient definition to reflect participant need as measured by the Inventory for Client and Agency Planning (ICAP) Service Score and other needed interventions, for services with tiered rates.
• Facilitate regular updates – the methods and data used to establish rates are formula-driven, which should facilitate updates to rates in future periods.
• Increased transparency - the methods and data used to establish rates are publicly available, easily understood and established through an open and public process.

• Fiscal stability for providers and for the State of Wyoming – the rate methodology is prospective in nature, and rates should be known in advance of services being provided. Enhanced predictability will allow for providers to better manage the costs of their operations. It will also allow the State to more easily project and budget for appropriate funding levels for services provided under the waivers managed by the Division.

Based on these objectives, the DD Division, assisted by a consultant, developed standardized rates state-wide for the services provided under the Adult, Child and ABI Waivers that are tied to variables in participants' ICAP needs assessments. To achieve this goal, the consulting firm used an independent rate model development approach that incorporates data related to wages, overhead, productivity, staffing ratios and other factors to create a proposed rate for each service and service level. The assumptions made for each proposed rate are based on data reported by the HCBS providers in Wyoming through a cost and wage survey process, and through other public sources of cost information. The standardized rates established for services under this approach achieved all of the objectives described above. Furthermore, the rates are to be re-based every two to four years.

As a result of the rate methodology the Wyoming legislature passed house bill 52 in 2008 to phase in the methodology as individual plans of care renew or begin July 1, 2008 with full implementation beginning July 1, 2009 (SFY-2010). This house bill added section g to Wyoming Statute 42-4-120.

The DD Division, assisted by a consultant, established a service provider working group to guide the rate development; this included 4 CARF service providers. This working group had 5 meetings to review the process and provide input. On November 1, 2007, the Division and consultant held a meeting inviting the 20 largest DD Waiver service providers in the State to review the proposed rates and provided impact analysis. The service providers had the opportunity to ask questions and provide input. Furthermore, there were 4 legislative committee meetings in calendar year 2007 by the Select Committee on Developmental Programs in which the rate setting process and concepts were presented and the public, including service providers, families and guardians had the opportunity to comment on the rate setting process.

All rate determination methods and the resulting rates are reviewed and approved by the Wyoming Department of Health, Wyoming's Medicaid agency. In addition to the public process described above, the Medicaid Agency also solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the Waiver are proposed. The notice is published in accordance with federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Whenever rates change, the Division makes listings of all covered services and corresponding rates available to clients and their families and service providers.

Information on payment rates are available to participants as part of the regular team meetings, are posted on the DD Divisions website and are available upon request.

SELF-DIRECTED SERVICES:
In the case of self-directed services utilizing the Financial Management Service Agency with Choice model with employer authority only, the provider managed rate methodology is utilized, as described above. One exception is the Agency with Choice Service. For this service only, the per member per month fee for the Fiscal/Employer Agent model under Administrative Authority is adjusted down to exclude components already covered in the provider managed rate methodology (i.e. payroll).

In the case of self-directed services utilizing the Financial Management Service Fiscal/Employer Agent model with employer and budget authority, the participant does not utilize the provider managed rate methodology. Instead, the participant can choose to pay their staff a wage within a wage range. The cost to the participant's individual budget is the wage plus employer payroll taxes, state and federal unemployment taxes and workers' compensation, if applicable. Additionally, the participant may increase the wage to assist with employee medical benefits. The wage minimum is based upon the federal minimum wage and the wage maximum is based upon the 90th percentile wage as of March 2009 per the Wyoming Department of Employment, by type of service. Wage ranges for services provided in a group setting are adjusted by the assumed staffing ratio.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Wyoming Medicaid Management Information System (MMIS) is the system used to accept and process claims for services rendered by the ABI waiver providers. Providers are required to submit electronic claims using an electronic software system or via web online entry, which are both direct input tools to the Wyoming MMIS. Once a provider submits a claim, the claim enters the MMIS and is processed through the processing cycle, which includes all edits and audits.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

- [ ] **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

- [ ] **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All service requests are reviewed and pre-approved by a waiver specialist in the Developmental Disabilities Division. The specialist reviews the service descriptions, units, rates, and quantity to see that the total amount of services requested is within the IBA. The specialist verifies the provider is certified for the requested service and that the units requested do not exceed the specified methodology.

All services must receive a prior authorization number that is assigned through the MMIS. All billing for waiver services is submitted electronically through MMIS and all providers are paid through that system. There are many edits built into the MMIS that do not allow payment for more units or dollar requests above the amount approved. System edits include service codes with set rates, limits on number of days that can be billed in a month, number of hours that can be billed in a day, and other time specific rules which limit the amount of services that can be billed.

Since all claims are submitted electronically using a Prior Authorization number, the MMIS utilizes edits to assure that payments never exceed authorization. No waiver services are authorized without a Prior Authorization number.

An individual must be an active Medicaid recipient enrolled in the ABI Waiver program in order for services to be processed and paid for. This assurance is an integral component managed by the Wyoming Medicaid Management Information System (MMIS).
The MMIS requires an individual to be:
- Enrolled in Medicaid
- Enrolled in a program (in this case, the ABI Waiver program)

Additional checks regarding services rendered, including appropriate provider type, no duplicate claims submitted, etc. are also performed.
The Wyoming Claims Processing Subsystem uses a Recipient Master File to verify recipient eligibility for services billed by a provider. Once an individual becomes eligible for services, the participant's eligibility information is updated in the MMIS. Only services in the client's plan will be covered based on limits established by the prior authorization number assigned to the service. The MMIS posts exceptions if a recipient is not eligible on the service date or is restricted from the service (as indicated in the service restrictions on the Recipient Master File). Service restrictions may include restricting the recipient to a particular provider for treatment or placing the recipient on review.

The MMIS checks other service limitations by referencing recipient Medicaid eligibility, TPL, and by various benefit plan specific limits established by the Utilization Review (UR) Criteria File.

Each claim processed by the Wyoming Claims Processing cycle (regardless of the entry method) has to pass the provider eligibility edit module. The Provider Master File verifies that the provider is actively enrolled and licensed according to the benefit plan for the category of service and dates of service. It also verifies any special restrictions for the provider for the service date on the claim. For each test that fails, the MMIS posts an exception code. The claim is adjudicated according to the exception disposition codes maintained on the Exception Control File.
The Claims Processing Subsystem also uses several edits to verify the reasonableness of provider charges. First the system performs internal balancing of claim charges. Second, the system edits and checks each service charge against pricing information on the reference files.
Medicaid determines the disposition of the exception codes posting to claims and the system maintains this information on line in the Exception Code File. The Claims Processing Subsystem has the capability of allowing the force payment of services on an exceptional basis, as directed in writing by Medicaid.

Through the life of a claim, the system retains in the claim record all exception codes posting to the claim, the adjudication ID of the person who forced or denied any exceptions to the claim, and the date and adjudication ID of the last person who worked on the claim. These features provide an audit trail to support the claim's payment process.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for

expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly

expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Costs related to room and board for clients, as well as facility maintenance, upkeep and improvement related to residential program services are not covered by the ABI waiver. These costs were excluded from the total costs collected for the rate determination and are therefore excluded from the payment rates. The payment rates are based solely on service costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

No. The State does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	40079.13	6471.00	46550.13	207740.00	937.00	208677.00	162126.87
2	42284.43	6471.00	48755.43	207740.00	937.00	208677.00	159921.57
3	42284.43	6471.00	48755.43	207740.00	937.00	208677.00	159921.57
4	42284.43	6471.00	48755.43	207740.00	937.00	208677.00	159921.57
5	42284.43	6471.00	48755.43	207740.00	937.00	208677.00	159921.57

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR

Year 1	**215**	215
Year 2	**215**	215
Year 3	**215**	215
Year 4 (renewal only)	**215**	215
Year 5 (renewal only)	**215**	215

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay estimate is calculated by taking the total number of days waiver recipients received waiver coverage during the waiver year divided by the number of unduplicated recipient count. Total days of waiver coverage = last-date-of-service - first-date-of-service + 1. If a recipient becomes institutionalized during the time of waiver coverage, those days are excluded from the calculation. The average length of stay reported in the SFY-2007 CMS-372 decreased by 5% for SFY-2008, based upon reports generated from the Medicaid Management Information System (MMIS), which is the report used to complete the CMS-372. The SFY-2008 MMIS data will be used for each year of the waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Factor D is calculated by multiplying the estimated number of users/service by the units/user and cost/unit. This calculation results in a total estimated expenditure for each service. All of the estimated component costs are totaled to get a total estimated expenditure for the wavier. Finally, the total estimated figure is divided by the total number of unduplicated recipients to arrive at an average cost per recipient, Factor D.

The Factor D reported in the SFY-2007 CMS-372 decreased by 1% for SFY-2008, based upon reports generated from the Medicaid Management Information system (MMIS), which is the report used to complete the CMS-372. Additional changes to Factor D in the forthcoming waiver years are estimated as follows:
- Estimated number of users:
Step 1: Use the SFY-2008 MMIS report data.
Step 2: Adjust the total estimated unduplicated count for any additional participants due to additional funding provided to reduce the waiting list, if applicable.
Step 3: Apply a percentage of participants who utilize a service based upon the ratio in the SFY-2008 MMIS report data.
- Estimated units/user:
Step 1: Use the SFY-2008 MMIS claims data to calculate the average units/user and round up to the next whole number.
Step 2: Convert any services that have a unit change from the SFY-2008 MMIS data, if applicable.
- Estimated cost/unit:
Step 1: Use the published rates current to the wavier year.
Step 2: For those services that have multiply rates based upon level of care, calculate an average

cost/unit/service.
Step 3: Apply an inflation/deflation factor to the cost/unit due to increases or decreases in funding provided for service rates by waiver year, if applicable.
Step 4: Convert any services that have a unit change from the SFY-2008 MMIS data, if applicable.
Step 5: For those services with an event unit, utilize the average paid amount in the SFY-2008 MMIS data.

Service changes:
In – Home Support Service – Phase out in year one. The phasing out of this service in the first year estimates that 20% of the annualized units/user in SFY-2008 will be utilized in the transition year.

Prevocational – Phase out in year one. The phasing out of this service in the first year estimates that 20% of the annualized units/user in SFY-2008 will be utilized in the transition year.

Day Habilitation:
Estimated number of users: Estimates that those receiving prevocational services will transition to the Day Habilitation.
Estimated units/user: Estimate the average units/user will equal the number of units/user for day habilitation in SFY-2008. For those that choose the 15 minute unit option, the day unit is multiplied by 15 (3.75 hours) to convert to the estimated 15 minute units.
Estimated cost/unit: Utilize the posted rates.

New Services:
Supported Living –
Estimated number of users: Estimates that those receiving In-Home Support will transition to the Supported Living service.
Estimated units/user: Estimate the average units/user will equal the number of units/user for residential habilitation.
Estimated cost/unit: Utilize the posted rates.

Service changes for wavier amendment years 2 through 5.

Service unit change:
The Residentail Habilitation Intervention and Day Habilitation Intervention services will be converted from an hourly unit to a 15 minute unit.

New Services:
The following services will be new: Agency with Choice Service, Homemaker, Independent Support Broker, Companion Services, Individual Directed Goods and Services, and Unpaid Caregiver Training.

Agency with Choice Service –
Estimated number of users: Estimate that 5% of participants will utilize this service. Estimated units/user: Estimate the average units/user will be monthly or 12 units per year. Estimated cost/unit: Utilize the posted rates.

Homemaker –
Estimated number of users: Estimate that 10% of participants will utilize this service. Estimated units/user: Estimate the average units/user will be same as other Waivers administered by the DD Division with this service. Estimated cost/unit: Utilize the posted rates.

Independent Support Broker –
Estimated number of users: Estimate that 15% of participants will utilize this service. Estimated units/user: Estimate the average units/user will be 384 15 minutes per year. Estimated cost/unit: Utilize the posted rates.

Companion Service –
Estimated number of users: Estimate that 10% of participants will utilize this service. Estimated units/user: Estimate the average units/user will be 50% of the average adult respite units/user. Estimated cost/unit: Utilize the posted rates.

Individual Directed Goods and Services –
Estimated number of users: Estimate that 10% of participants will utilize this service. Estimated units/user: Estimate the average units/user will be ten. Estimated cost/unit: Estimate that the average cost

will be $200 or a total of $2,000 equal to the maximum allowed.

Unpaid Caregiver Training – Estimate that 5% of participants will utilize this service. Estimated units/user: Estimate the average units/user will be two times per year. Estimated cost/unit: Utilize the maximum allowed of $2,000 for this service divided by two.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is the estimated annual average per capita Medicaid cost for all services that are furnished in addition to waiver services while the individual is in the waiver.

Step 1: The Factor D' reported in the SFY-2007 CMS-372 decreased by 6% for SFY-2008, based upon reports generated from the Medicaid Management Information system (MMIS), which is the report used to complete the CMS-372.
Step 2: Use the SFY-2008 MMIS report data.
Step 3: Increase the estimated cost by 6% for year 1 of the waiver due to inflation. In subsequent years the estimate remains unchanged from year 1.

The prescribed drugs furnished to Medicare/Medicaid dual eligibles under the provisions of Part D are not processed through the State's MMIS and are therefore excluded from the MMIS reporting and from Factor D'.

Factor D' includes institutional costs when a person leaves the waiver for the institution and returns to the waiver in the same waiver year.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G value must reflect the average per capita cost for the level(s) of institutional care that would otherwise be furnished to waiver participants.

Step 1: The Factor G reported in the SFY-2007 CMS-372 decreased by 1% for SFY-2008, based upon reports generated from the Medicaid Management Information system (MMIS), which is the report used to complete the CMS-372.
Step 2: Use the SFY-2008 MMIS actual data
Step 3: Increase the estimated cost by 4% for year 1 of the waiver due to inflation. In subsequent years the estimate remains unchanged from year 1.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' includes the average per capita cost of all other Medicaid services furnished while the individual is institutionalized (including State plan and expanded EPSDT services) and the cost of short term hospitalization (furnished with the expectation that the person would return to the institution).

Step 1: The Factor G' reported in the SFY-2007 CMS-372 increase by $257 per capita for SFY-2008, based upon reports generated from the Medicaid Management Information System (MMIS), which is the report used to complete the CMS-372.
Step 2: Use the SFY-2008 MMIS actual data
Step 3: Increase the estimated cost by 6% for year 1 of the waiver due to inflation. In subsequent years the estimate remains unchanged from year 1.

The prescribed drugs furnished to Medicare/Medicaid dual eligibles under the provisions of Part D are not processed through the State's MMIS and are therefore excluded from the MMIS reporting and from Factor G'.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to

add these components.

Waiver Services
Case Management
Community Integrated Employment
Day Habilitation
Homemaker
Personal Care
Prevocational Services - phased out Year 1
Residential Habilitation
Respite
Supported Living
Occupational Therapy
Physical Therapy
Speech Therapy
Agency with Choice
Independent Support Broker
Cognitive Retraining
Companion Services
Dietician Services
Environmental Modifications
In Home Support - phased out Year 1
Individually-Directed Goods and Services
Skilled Nursing
Specialized Equipment
Unpaid Caregiver Training and Education

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**719095.10**
case management	month	215	11.00	282.90	**669058.50**	
subsequent assessments	event	58	1.00	862.70	**50036.60**	
Community Integrated Employment Total:						**246264.00**
Group Supported Employment	15 minute	4	2370.00	2.84	**26923.20**	
Individual Community Integrated Employment	15 minute	20	1536.00	7.14	**219340.80**	

Day Habilitation Total:						**1314348.18**
Day Habilitation (daily)	day	88	158.00	81.27	**1129978.08**	
Day Habilitation (15 minute)	15 minute	22	2370.00	3.12	**162676.80**	
Intervention (Day)	hour	5	167.00	25.98	**21693.30**	
Invervention (Day)	15 minute	0	0.00	0.01	**0.00**	
Homemaker Total:						**0.00**
Homemaker	15 minute	0	0.00	0.01	**0.00**	
Personal Care Total:						**257580.00**
Personal Care	15 minute	20	3180.00	4.05	**257580.00**	
Prevocational Services - phased out Year 1 Total:						**31661.28**
Prevocational Services - phased out Year 1	day	21	24.00	62.82	**31661.28**	
Residential Habilitation Total:						**3800604.03**
Residential Habilitation	day	107	237.00	149.37	**3787873.83**	
Intervention (Residential)	hour	7	70.00	25.98	**12730.20**	
Intervention (Residential)	15 minute	0	0.00	0.01	**0.00**	
Respite Total:						**106984.96**
Respite	15 minute	16	1817.00	3.68	**106984.96**	
Supported Living Total:						**1428130.00**
Supported Living (daily)	day	44	275.00	93.40	**1130140.00**	
Supported Living (individual)	15 minute	6	4125.00	8.70	**215325.00**	
Supported Living (group)	15 minute	6	4125.00	3.34	**82665.00**	
Occupational Therapy Total:						**64923.75**
Occupational Therapy	15 minute	25	145.00	17.91	**64923.75**	
Occupational Therapy (group)	15 minute	0	0.00	6.86	**0.00**	
Physical Therapy Total:						**45089.44**
Physical Therapy	15 minute	17	121.00	21.92	**45089.44**	
Physical Therapy (group)	15 minute	0	0.00	8.40	**0.00**	
Speech Therapy Total:						**86237.39**
Speech Therapy	15 minute	33	137.00	17.66	**79840.86**	
Speech Therapy (group)	15 minute	7	137.00	6.67	**6396.53**	
Agency with Choice Total:						**0.00**

Agency with Choice	month	0	0.00	0.01	**0.00**	
Independent Support Broker Total:						**0.00**
Independent Support Broker	15 minute	0	0.00	0.01	**0.00**	
Cognitive Retraining Total:						**14305.80**
Cognitive Retraining	15 minute	5	339.00	8.44	**14305.80**	
Companion Services Total:						**0.00**
Companion Services	15 minute	0	0.00	0.01	**0.00**	
Companion Services (group)	15 minute	0	0.00	0.01	**0.00**	
Dietician Services Total:						**301.40**
Dietician Services	15 minute	1	20.00	15.07	**301.40**	
Environmental Modifications Total:						**111610.26**
Environmental Modifications (New)	event	9	1.00	12401.14	**111610.26**	
Environmental Modifications (Repair)	event	0	0.00	0.01	**0.00**	
In Home Support - phased out Year 1 Total:						**115008.85**
In Home Support - phased out Year 1	hour	55	67.00	31.21	**115008.85**	
Individually-Directed Goods and Services Total:						**0.00**
Individually-Directed Goods and Services	event	0	0.00	0.01	**0.00**	
Skilled Nursing Total:						**230337.25**
Skilled Nursing	15 minute	55	221.00	18.95	**230337.25**	
Specialized Equipment Total:						**44530.56**
Specialized Equipment (New)	event	32	1.00	1391.58	**44530.56**	
Specialized Equipment (Repair)	event	0	0.00	0.01	**0.00**	
Unpaid Caregiver Training and Education Total:						**0.00**
Unpaid Caregiver Training and Education	event	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**8617012.25**
Total Estimated Unduplicated Participants:	**215**
Factor D (Divide total by number of participants):	**40079.13**
Average Length of Stay on the Waiver:	318

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**750713.00**
case management	month	215	12.00	271.58	**700676.40**	
subsequent assessments	event	58	1.00	862.70	**50036.60**	
Community Integrated Employment Total:						**236312.40**
Group Supported Employment	15 minute	4	2370.00	2.73	**25880.40**	
Individual Community Integrated Employment	15 minute	20	1536.00	6.85	**210432.00**	
Day Habilitation Total:						**1258436.64**
Day Habilitation (daily)	day	88	158.00	77.76	**1081175.04**	
Day Habilitation (15 minute)	15 minute	22	2370.00	3.00	**156420.00**	
Intervention (Day)	hour	0	0.00	0.01	**0.00**	
Invervention (Day)	15 minute	5	668.00	6.24	**20841.60**	
Homemaker Total:						**32676.00**
Homemaker	15 minute	30	280.00	3.89	**32676.00**	
Personal Care Total:						**247404.00**
Personal Care	15 minute	20	3180.00	3.89	**247404.00**	
Prevocational Services - phased out Year 1 Total:						**0.00**
Prevocational Services - phased out Year 1	day	0	0.00	0.01	**0.00**	
Residential Habilitation Total:						**4237954.65**
Residential Habilitation	day	107	275.00	143.61	**4225724.25**	
Intervention (Residential)	hour	0	0.00	0.01	**0.00**	
Intervention (Residential)	15 minute	7	280.00	6.24	**12230.40**	
Respite Total:						**102624.16**
Respite	15 minute	16	1817.00	3.53	**102624.16**	
Supported Living Total:						**1381143.50**
Supported Living (daily)	day	44	275.00	89.66	**1084886.00**	
Supported Living (individual)	15 minute	6	4275.00	8.35	**214177.50**	
Supported Living (group)	15 minute	6	4275.00	3.20	**82080.00**	

Occupational Therapy Total:						**62313.75**
Occupational Therapy	15 minute	25	145.00	17.19	**62313.75**	
Occupational Therapy (group)	15 minute	0	0.00	6.59	**0.00**	
Physical Therapy Total:						**43279.28**
Physical Therapy	15 minute	17	121.00	21.04	**43279.28**	
Physical Therapy (group)	15 minute	0	0.00	8.06	**0.00**	
Speech Therapy Total:						**82864.45**
Speech Therapy	15 minute	33	137.00	16.95	**76630.95**	
Speech Therapy (group)	15 minute	7	137.00	6.50	**6233.50**	
Agency with Choice Total:						**6813.84**
Agency with Choice	month	11	12.00	51.62	**6813.84**	
Independent Support Broker Total:						**120890.88**
Independent Support Broker	15 minute	33	384.00	9.54	**120890.88**	
Cognitive Retraining Total:						**13729.50**
Cognitive Retraining	15 minute	5	339.00	8.10	**13729.50**	
Companion Services Total:						**70465.68**
Companion Services	15 minute	18	909.00	3.89	**63648.18**	
Companion Services (group)	15 minute	5	909.00	1.50	**6817.50**	
Dietician Services Total:						**289.40**
Dietician Services	15 minute	1	20.00	14.47	**289.40**	
Environmental Modifications Total:						**111610.59**
Environmental Modifications (New)	event	6	1.00	7283.93	**43703.58**	
Environmental Modifications (Repair)	event	3	1.00	22635.67	**67907.01**	
In Home Support - phased out Year 1 Total:						**0.00**
In Home Support - phased out Year 1	hour	0	0.00	0.01	**0.00**	
Individually-Directed Goods and Services Total:						**44000.00**
Individually-Directed Goods and Services	event	22	10.00	200.00	**44000.00**	
Skilled Nursing Total:						**221099.45**
Skilled Nursing	15 minute	55	221.00	18.19	**221099.45**	
Specialized Equipment Total:						**44530.77**
Specialized Equipment (New)	event	29	1.00	1477.44	**42845.76**	

Specialized Equipment (Repair)	event	3	1.00	561.67	**1685.01**	
Unpaid Caregiver Training and Education Total:						**22000.00**
Unpaid Caregiver Training and Education	event	11	2.00	1000.00	**22000.00**	
				GRAND TOTAL:		**9091151.94**
				Total Estimated Unduplicated Participants:		**215**
				Factor D (Divide total by number of participants):		**42284.43**
				Average Length of Stay on the Waiver:		318

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**750713.00**
case management	month	215	12.00	271.58	**700676.40**	
subsequent assessments	event	58	1.00	862.70	**50036.60**	
Community Integrated Employment Total:						**236312.40**
Group Supported Employment	15 minute	4	2370.00	2.73	**25880.40**	
Individual Community Integrated Employment	15 minute	20	1536.00	6.85	**210432.00**	
Day Habilitation Total:						**1258436.64**
Day Habilitation (daily)	day	88	158.00	77.76	**1081175.04**	
Day Habilitation (15 minute)	15 minute	22	2370.00	3.00	**156420.00**	
Intervention (Day)	hour	0	0.00	0.01	**0.00**	
Invervention (Day)	15 minute	5	668.00	6.24	**20841.60**	
Homemaker Total:						**32676.00**
Homemaker	15 minute	30	280.00	3.89	**32676.00**	
Personal Care Total:						**247404.00**
Personal Care	15 minute	20	3180.00	3.89	**247404.00**	
Prevocational Services - phased out Year 1 Total:						**0.00**
Prevocational Services -						

phased out Year 1	day	0	0.00	0.01	**0.00**	
Residential Habilitation Total:						**4237954.65**
Residential Habilitation	day	107	275.00	143.61	**4225724.25**	
Intervention (Residential)	hour	0	0.00	0.01	**0.00**	
Intervention (Residential)	15 minute	7	280.00	6.24	**12230.40**	
Respite Total:						**102624.16**
Respite	15 minute	16	1817.00	3.53	**102624.16**	
Supported Living Total:						**1381143.50**
Supported Living (daily)	day	44	275.00	89.66	**1084886.00**	
Supported Living (individual)	15 minute	6	4275.00	8.35	**214177.50**	
Supported Living (group)	15 minute	6	4275.00	3.20	**82080.00**	
Occupational Therapy Total:						**62313.75**
Occupational Therapy	15 minute	25	145.00	17.19	**62313.75**	
Occupational Therapy (group)	15 minute	0	0.00	6.59	**0.00**	
Physical Therapy Total:						**43279.28**
Physical Therapy	15 minute	17	121.00	21.04	**43279.28**	
Physical Therapy (group)	15 minute	0	0.00	8.06	**0.00**	
Speech Therapy Total:						**82864.45**
Speech Therapy	15 minute	33	137.00	16.95	**76630.95**	
Speech Therapy (group)	15 minute	7	137.00	6.50	**6233.50**	
Agency with Choice Total:						**6813.84**
Agency with Choice	month	11	12.00	51.62	**6813.84**	
Independent Support Broker Total:						**120890.88**
Independent Support Broker	15 minute	33	384.00	9.54	**120890.88**	
Cognitive Retraining Total:						**13729.50**
Cognitive Retraining	15 minute	5	339.00	8.10	**13729.50**	
Companion Services Total:						**70465.68**
Companion Services	15 minute	18	909.00	3.89	**63648.18**	
Companion Services (group)	15 minute	5	909.00	1.50	**6817.50**	
Dietician Services Total:						**289.40**
Dietician Services	15 minute	1	20.00	14.47	**289.40**	

Environmental Modifications Total:						**111610.59**
Environmental Modifications (New)	event	6	1.00	7283.93	**43703.58**	
Environmental Modifications (Repair)	event	3	1.00	22635.67	**67907.01**	
In Home Support - phased out Year 1 Total:						**0.00**
In Home Support - phased out Year 1	hour	0	0.00	0.01	**0.00**	
Individually-Directed Goods and Services Total:						**44000.00**
Individually-Directed Goods and Services	event	22	10.00	200.00	**44000.00**	
Skilled Nursing Total:						**221099.45**
Skilled Nursing	15 minute	55	221.00	18.19	**221099.45**	
Specialized Equipment Total:						**44530.77**
Specialized Equipment (New)	event	29	1.00	1477.44	**42845.76**	
Specialized Equipment (Repair)	event	3	1.00	561.67	**1685.01**	
Unpaid Caregiver Training and Education Total:						**22000.00**
Unpaid Caregiver Training and Education	event	11	2.00	1000.00	**22000.00**	

GRAND TOTAL:	**9091151.94**
Total Estimated Unduplicated Participants:	**215**
Factor D (Divide total by number of participants):	**42284.43**
Average Length of Stay on the Waiver:	318

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**750713.00**
case management	month	215	12.00	271.58	**700676.40**	
subsequent assessments	event	58	1.00	862.70	**50036.60**	
Community Integrated Employment Total:						**236312.40**
Group Supported Employment	15 minute	4	2370.00	2.73	**25880.40**	
Individual Community						

Integrated Employment	15 minute	20	1536.00	6.85	**210432.00**	
Day Habilitation Total:						**1258436.64**
Day Habilitation (daily)	day	88	158.00	77.76	**1081175.04**	
Day Habilitation (15 minute)	15 minute	22	2370.00	3.00	**156420.00**	
Intervention (Day)	hour	0	0.00	0.01	**0.00**	
Invervention (Day)	15 minute	5	668.00	6.24	**20841.60**	
Homemaker Total:						**32676.00**
Homemaker	15 minute	30	280.00	3.89	**32676.00**	
Personal Care Total:						**247404.00**
Personal Care	15 minute	20	3180.00	3.89	**247404.00**	
Prevocational Services - phased out Year 1 Total:						**0.00**
Prevocational Services - phased out Year 1	day	0	0.00	0.01	**0.00**	
Residential Habilitation Total:						**4237954.65**
Residential Habilitation	day	107	275.00	143.61	**4225724.25**	
Intervention (Residential)	hour	0	0.00	0.01	**0.00**	
Intervention (Residential)	15 minute	7	280.00	6.24	**12230.40**	
Respite Total:						**102624.16**
Respite	15 minute	16	1817.00	3.53	**102624.16**	
Supported Living Total:						**1381143.50**
Supported Living (daily)	day	44	275.00	89.66	**1084886.00**	
Supported Living (individual)	15 minute	6	4275.00	8.35	**214177.50**	
Supported Living (group)	15 minute	6	4275.00	3.20	**82080.00**	
Occupational Therapy Total:						**62313.75**
Occupational Therapy	15 minute	25	145.00	17.19	**62313.75**	
Occupational Therapy (group)	15 minute	0	0.00	6.59	**0.00**	
Physical Therapy Total:						**43279.28**
Physical Therapy	15 minute	17	121.00	21.04	**43279.28**	
Physical Therapy (group)	15 minute	0	0.00	8.06	**0.00**	
Speech Therapy Total:						**82864.45**
Speech Therapy	15 minute	33	137.00	16.95	**76630.95**	
Speech Therapy (group)	15 minute	7	137.00	6.50	**6233.50**	

Agency with Choice Total:						**6813.84**
Agency with Choice	month	11	12.00	51.62	**6813.84**	
Independent Support Broker Total:						**120890.88**
Independent Support Broker	15 minute	33	384.00	9.54	**120890.88**	
Cognitive Retraining Total:						**13729.50**
Cognitive Retraining	15 minute	5	339.00	8.10	**13729.50**	
Companion Services Total:						**70465.68**
Companion Services	15 minute	18	909.00	3.89	**63648.18**	
Companion Services (group)	15 minute	5	909.00	1.50	**6817.50**	
Dietician Services Total:						**289.40**
Dietician Services	15 minute	1	20.00	14.47	**289.40**	
Environmental Modifications Total:						**111610.59**
Environmental Modifications (New)	event	6	1.00	7283.93	**43703.58**	
Environmental Modifications (Repair)	event	3	1.00	22635.67	**67907.01**	
In Home Support - phased out Year 1 Total:						**0.00**
In Home Support - phased out Year 1	hour	0	0.00	0.01	**0.00**	
Individually-Directed Goods and Services Total:						**44000.00**
Individually-Directed Goods and Services	event	22	10.00	200.00	**44000.00**	
Skilled Nursing Total:						**221099.45**
Skilled Nursing	15 minute	55	221.00	18.19	**221099.45**	
Specialized Equipment Total:						**44530.77**
Specialized Equipment (New)	event	29	1.00	1477.44	**42845.76**	
Specialized Equipment (Repair)	event	3	1.00	561.67	**1685.01**	
Unpaid Caregiver Training and Education Total:						**22000.00**
Unpaid Caregiver Training and Education	event	11	2.00	1000.00	**22000.00**	
				GRAND TOTAL:		**9091151.94**
				Total Estimated Unduplicated Participants:		**215**
				Factor D (Divide total by number of participants):		**42284.43**
				Average Length of Stay on the Waiver:		318

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**750713.00**
case management	month	215	12.00	271.58	**700676.40**	
subsequent assessments	event	58	1.00	862.70	**50036.60**	
Community Integrated Employment Total:						**236312.40**
Group Supported Employment	15 minute	4	2370.00	2.73	**25880.40**	
Individual Community Integrated Employment	15 minute	20	1536.00	6.85	**210432.00**	
Day Habilitation Total:						**1258436.64**
Day Habilitation (daily)	day	88	158.00	77.76	**1081175.04**	
Day Habilitation (15 minute)	15 minute	22	2370.00	3.00	**156420.00**	
Intervention (Day)	hour	0	0.00	0.01	**0.00**	
Invervention (Day)	15 minute	5	668.00	6.24	**20841.60**	
Homemaker Total:						**32676.00**
Homemaker	15 minute	30	280.00	3.89	**32676.00**	
Personal Care Total:						**247404.00**
Personal Care	15 minute	20	3180.00	3.89	**247404.00**	
Prevocational Services - phased out Year 1 Total:						**0.00**
Prevocational Services - phased out Year 1	day	0	0.00	0.01	**0.00**	
Residential Habilitation Total:						**4237954.65**
Residential Habilitation	day	107	275.00	143.61	**4225724.25**	
Intervention (Residential)	hour	0	0.00	0.01	**0.00**	
Intervention (Residential)	15 minute	7	280.00	6.24	**12230.40**	
Respite Total:						**102624.16**
Respite	15 minute	16	1817.00	3.53	**102624.16**	
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Supported Living (daily)	day	44	275.00	89.66	**1084886.00**	
Supported Living (individual)	15 minute	6	4275.00	8.35	**214177.50**	
Supported Living (group)	15 minute	6	4275.00	3.20	**82080.00**	

Occupational Therapy Total:						**62313.75**
Occupational Therapy	15 minute	25	145.00	17.19	**62313.75**	
Occupational Therapy (group)	15 minute	0	0.00	6.59	**0.00**	
Physical Therapy Total:						**43279.28**
Physical Therapy	15 minute	17	121.00	21.04	**43279.28**	
Physical Therapy (group)	15 minute	0	0.00	8.06	**0.00**	
Speech Therapy Total:						**82864.45**
Speech Therapy	15 minute	33	137.00	16.95	**76630.95**	
Speech Therapy (group)	15 minute	7	137.00	6.50	**6233.50**	
Agency with Choice Total:						**6813.84**
Agency with Choice	month	11	12.00	51.62	**6813.84**	
Independent Support Broker Total:						**120890.88**
Independent Support Broker	15 minute	33	384.00	9.54	**120890.88**	
Cognitive Retraining Total:						**13729.50**
Cognitive Retraining	15 minute	5	339.00	8.10	**13729.50**	
Companion Services Total:						**70465.68**
Companion Services	15 minute	18	909.00	3.89	**63648.18**	
Companion Services (group)	15 minute	5	909.00	1.50	**6817.50**	
Dietician Services Total:						**289.40**
Dietician Services	15 minute	1	20.00	14.47	**289.40**	
Environmental Modifications Total:						**111610.59**
Environmental Modifications (New)	event	6	1.00	7283.93	**43703.58**	
Environmental Modifications (Repair)	event	3	1.00	22635.67	**67907.01**	
In Home Support - phased out Year 1 Total:						**0.00**
In Home Support - phased out Year 1	hour	0	0.00	0.01	**0.00**	
Individually-Directed Goods and Services Total:						**44000.00**
Individually-Directed Goods and Services	event	22	10.00	200.00	**44000.00**	
Skilled Nursing Total:						**221099.45**
Skilled Nursing	15 minute	55	221.00	18.19	**221099.45**	
Specialized Equipment Total:						**44530.77**
Specialized Equipment (New)	event	29	1.00	1477.44	**42845.76**	

Specialized Equipment (Repair)	event	3	1.00	561.67	**1685.01**	
Unpaid Caregiver Training and Education Total:						**22000.00**
Unpaid Caregiver Training and Education	event	11	2.00	1000.00	**22000.00**	

GRAND TOTAL:	**9091151.94**
Total Estimated Unduplicated Participants:	**215**
Factor D (Divide total by number of participants):	**42284.43**
Average Length of Stay on the Waiver:	318